			For State Registrar	State of Maryland	-	rtment of H		- 1	giene Reg. No. () ()	14 2	3501
	Physici		1. Decedent's Name (First, Middle, La	Michael L.	Smith			2. Date of Dea	6.0	Year	3. Time of Death
i de	/Medic Examin		4a. Facility Name (If not institution, git 72/3 Kirdm	re street and number)	_	4b. City, Town, or LAN S	Location of Deat	th	Ac. County	of Death	eorgeis
	Funeral Director		219-64-6128	Sex 7. Age (In yrs. I IN M 2□ F 51	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year) 3, 1953	Country	ington DC
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's	, Town or Lo		ınham		· · · · · · · · · · · · · · · · · · ·	10d	I. Inside City Limits 1 ▼Yes 2 □ No
	3a or 28a	Il Directo	10e. Street and Number 7213 Kidmore I			10f. Zip Code	706		10g. Citizen of W	Vhat Country USA	y?
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. Markad other than "natural", or litema 23a or 28a-1 show markad other than "natural", or litema 23a or 28a-1 show marked other than "natural".	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes, 2 ☐ No If Yes, Give Year or Dates:	1	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Race Blac Specify	e - American k, White, etc	c.
215-0036	ithin 72 hourie. Ien "natural	Completed t	15. Decedent's Elementary/Secondary (0-12)	ducation	(Give life. L	ent's Usual Occupa kind of work done of OO NOT use retired	during most of wo f)	orking	16b. Kind of Bu		
Maryland 2121	filed w Hygier other th	Be Cor	12th 17. Father's Name (First, Middle, Las	υ	Pa	arts Stor		me (First, Middle,		vate	
ylan	should be and Mental markad o	ToB	Wilber L. Smit					is Dunkei			
	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship Wilber L. Smith		1.	g Address (Street a Kidmore				State, Zip C	code)
Baltimore,	Pages 1 ent of He nt: # itar y or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Other (Specific Specific Speci			sition (Name of natory or other place Cremator		Date 2/2004	20c. Location -		
Balti	permit. F Departm Importar any injur		21. Signature of Funeral Service Lice		22	Name and Addres	ss of Facility La	atimore I	Tuneral	Servi	ces
SPECIAL SECTION SECTIO	Physician /Medical Examiner	_	23a. Part1. Enter the disease, for shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Attacos de ach line. Due to (or as a consequence)	evetic uence of):	er the mode of dyin				وا	Approximate nterval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, loading to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence) d.							
.O. Box 6	at the death certifi by the attending tached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of de	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Dat	te of delivery onth D	/ Day Year
rds, P	The law requires that the site has been signed by the sage 2 should be detache	Ď	Pan II. Other significant conditions Saraphyre	contributing to death but not rest	ulting in the u	nderlying cause giv	en in Part I.		obacco use cont Yes 2 □ No	4	cause of death?
al Records,		Completed						24a. Was autoj perfo 1 Yes	psy prmed?/	Were autops prior to comp death? 1 \(Yes \(2 \)	sy findings available pletion of cause of
Vital	Phyaician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examinat?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 3 DOA Oth	00	eath (Check only only only only only only only only		er (Specify)	on-shows t
Division of	fing After fune	Certification; T	27. Manne of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Word M 1		28d. Describe	how injury occur	red	
N N			4 Homicide determined	building, etc. (Specify	v) 			City or To			
	To the Hospital or within 24 hours afte to the Funeral Discompletely filled in	Medical	29a. Certifier 1 ☐ Certifying P (Check only one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.	tion and/or in	restigation, in my o	pinion, death occ	curred at the time,	date and place,	and due to the	ted. he cause(s)
1	To t To t	Σ	29b. Signature and title of certifier	~/ 10 of	_ >	29c. Licens	e number	2	29d. Date signed	d (Month, Da	ay, Year)
			30. Name and address of person who	/		Print)	23 / 8		July	7 20	14
	Sta	-	31. Date filed (Month, Day, Year)	y 32! Registrar's Signa	ture	p) lat	Urg reg	Crev	ery	MA	y inna
	Registr	ar	JUL 0 9 2004	lacus do Ago	and I						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.? 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jump 2004 6P 9 **Physician** М Eugene Walker Shelor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 179 1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**√x**M 2□F Virginia Director 223 36 8392 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "naturel", or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Calvert Lusby Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20657 United States 870 Planters Wharf Road death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status perrit. Pages 1 and 2 should be filed within 72 hours atter or Department of Health and Mental Hygiene. Importent: if tiem 27 is marked other then "naturel", or liter any injury or other treumetic event, the Medical Examinations. 1 ∑XYes 2 ☐ No If Yes, Give Year or Date Karean War 1 Never Married 2 Married Speci**white** Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) heavy equipment operator construction 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rillie Scott Shelor Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lusby MD 20657 P.O. Box 41 Gloria J. Shelor- wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition st. Paul UM Cemetery 2004 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lusby Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) few hours Physician SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by and stage COPD, CHF, Renal Failure, HTN 1 res 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death 28b. Time of After 1 Atural s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 4 / Homicide within 24 hours a

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completely filled the Hospitel 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36969 110/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUSBY 2065) SCARIA MATHEW MD 11910 H- GTRUEMAN AD 31. Date filed (Month, Day, Year) JUL 12 32. Registras Signature State Bean & Spelle 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. N6) 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 July 6 11 P Katherine Elizabeth Stinnett **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 420 West Dares Beach Road Apt Calvert Prince If Under 1 Year Frederi 8. Date of Birth (Month, Day May 23 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) 914 1□M 2□E Maryland 90 217 36 6918 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Prince Frederick 1 □Yes 2 □XIO Calvert Maryland Director 10f. Zip Code 2 20678 10g. Citizen of What Country? 10e. Street and Number United States 420 West Dares Beach Rd. Apt 112 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 12 No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nora E. Fowler John Edward Gott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10390 Breeden Rd. Lusby MD 20657 Betty Cochrane - daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State EmmanuelCemetery July 9 2004 Huntingtown Marylar * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home 4405 Broomes Is. rd. Part Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final years COPA END STAGE mony disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

Physician /Medical Examiner

certificate be executed

Box 68760

Records, P.O.

Division of Vital

death.

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I Diractor: /

within 24 hours after dea To the Funeral Director completely filled in by th

Medical

Funeral

Director

"natural", or Items 23a or 28a-f show ofical Examiner must be notified at

other

Is markad ages 1 and 2 should be not of Health and Mentate If itam 27 Is marked

permit. Pages 1
Department of H
Important: If its
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within 72 hours after death with the Maryłand

Baltimore, Maryland 21215-0036

burial-transit and attending physician the use as Completed by peen Be Certification: To After

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA, SICCA COLON SIB CANCER MANDIBLE

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a Was an

1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 1 16

examiner?		1 (o medical
Manner of		5 Pendin
1 Catura	11	2 Pendin

2 Accident

3 T Suicide

4 - Homicide

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MELANDONA

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

HEMORRHOID

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

WD 50P2)

The critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dale and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

29c. License number D3696

LVSBY

29d. Date signed (Month, Day, Year) 8104

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCARIA MATHEWMS, 11910 H. G TRVEDANRD 31. Date filed (Month, Day Year) 0 8

32. Registra's Signature 2004

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 1:50 PM July 11 Raymond L. Stigler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mt Airy Carroll Lorien Nursing & Rehab Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Ye June 16, 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) Months 1 X M 2 □ F 214 90 4914 1925 Marvland 79 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show in than "natural, or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Carroll Svkesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 United States 510 Buckhorn Road deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Howard County Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien important: if Item 21 is marked other the any injury or other traumatic accer-Custodian School Board 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emma Robinson Carl G. Stigler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 519 Lakeview Circle Littlestown, PA 17340 Dan Stigler/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lake View Cemetery 7-15-2004 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service J. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE Provsician 2 YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ been signed be should be deta Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown CERE BROVESCULAR DISFASE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Pl
 24 hours after death.
 Funeral Director: After the Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0060878 1215 2004 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACKRIVER NECKROPD ESSEN MARGLANT 109 NIVEDITA M-D. BANSAL 001 -11221. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 June 25, **Physician** 2040 Edward Merton Sparks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Kent Chestertown Chester River Hospital Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/31/1920 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 15√M 2□F Maryland 83 216-18-3721 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "naturel", or items 23e or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Oueen Anne's Sudlersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21668 USA 5616 Sudlersville Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ➡ No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Mechanic Aircraft 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bernice Evergram Oscar Sparks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5616 Sudlersville Road, Sudlersville, MD 21668 Fannie T. Sparks/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Garden 07/01/2004 Bel Air, Maryland ^{22.} Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, 370 W. Cypress Street, Millington, MD 216 21. Signature of Funeral Service Licensee Hellars rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Scherotic Cardio Vescular Diseas Syears Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ CVA 1999: TIA 1998; 1 Tes 2 No 3 Probably 4 Unknown Completed Periphoral Vascular Dispaso 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Dural Hourstonea Bilatoral 1□ Yes 2. No 1 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ို this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation I Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6/23/04 50996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brown St Chestertown MD 21620 31. Date filed (Month, Day, Year) rar's Signature 32. Reg State 2004 Registrar

CPM 04-04329 Franklin Story

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nklin Story		State of Maryland / Dep. State of Maryland / Dep. Ce	artment of Health and M rtificate of Death		Rag. No.	04	2350	6
Physiciar /Medica		1. Decedent's Name (First, Middle, Last) Franklin Fletcher Story		2. Date of De Month July	82,	2004	3. Time of De. 16:19	ath' M
Examine		4a. Facility Name (If not institution, give street and number) Chester River Hospital Center	4b. City, Town, or Location of Death Chestertown		Ken			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 216–54–9547 55 Yrs.	If Under 1 Year If Under 24 Hrs.	8. Date of Bin (Month, Da 02/27/2	tn, Year) 2004	Delar Delar	place (State or Fo ntry) Ware	oreign
Maryland 21215-0036 nd 2 should be filed within 72 hours after death vilth and Mental Hygiene. 27 is marked other than "natural", or items 236 r traumatic event, the Medical Expirition found	to Be Completed by Funeral Direc	10a. State 10b. County 10c. City, Town or L. Maryland Queen Anne's Sud 10e. Street and Number 224 E. Main Street 11. Marital Status 1. Was Decedent Ever in U.S. Amed Forces? 1. Yes 2. No If Yes, Give A Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12. Cons 16a. Dece (Give life.) 17a. Father's Name (First, Middle, Last) Louis Sudler Story, Sr.	1 Mayes 2 No 10g. Citizen of What Country? USA r No- 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Construction ddle, Maiden Surmame) DES DES DES DES DES DES DES DE					
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Hospital or 14 hours afte Funeral Diri	ledical Certi	29a. Certifier Check only Medical Examiner: On the basis of examination and/or is and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the	cause(s) and	manner as s	tated. o the cause(s)	
To the within 2 To the complet	Med	29b. Signature and title of certifier	29c. License number O.C.M.E.		290. Date sig	03, 2		
		30. National address of person who completed cause of teath (Item 23a) (Type 111) 31. Date filed (Month, Day, Year) 32. Registrate Signature	Penn Street, Balti	more, M	larylan	d 2120	1	
State Registra		JUL 0 6 2004	Specific					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Sweitzer 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospita umberland Allegany Ear | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb 20, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2 □ F 217-18-4912 83 1921 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. In: If item 27 is marked othar than "netural", or itams 23a or 28a-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or items 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at MDAllegany Rawlings 1 ☐Yes 2 ☐ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21004 McMullen Highway 21557 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Flagman B & O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John C. Sweitzer Homa A. (Bowser) Sweitzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Priest daughter 21004 McMullen Highway Rawlings MD 21557 20a. Method of Disposition

1 Daurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ Department of Important: If any injury or once. Sunset Memorial Park 7/17/2004 Cumberland MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Pagn. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ave115 Dulmougn disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Completed by Physician/Medical Examiner the burial-transit DYDUG that initiated events resulting in death) Last Due to (or as a consequ Records, P.O. Box 68760, use as IF FEMALE: (6/200 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of derivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Kidney 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 Yes 2 No 2 No 1 Tes 00 Division of Vital 25. Was case referred to me.... examiner? RELEAS CA erred to medical 26. Place of Death (Check only one) Hospital: Other: 3 DOA 1 Inpatient 2 ER/Outpatient ို 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To tha Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours a To the Funeral C

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D13601 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bishop Walsh Rd. Cumberland Dr. Victor 925 Felipa 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 6 2004

State Registrar

and manner stated.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) ^{Day} 2004 JULY 16, Year **Physician** ROBERT HENRY SCHLOTTENMEIER 11:13 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARROLL HOSPITAL CENTER CARROLL WESTMINSTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day Year) | MAY 1, 1929 9. Birthplace (State or Foreign Country) NEW JERSEY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 217-24-1535 75 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Mactical Exeminer must be notified at ty⊒Yes 2 □ No Directo WESTMINSTER MARYLAND CARROLL per 10e Street and Number 10f Zin Code 10g. Citizen of What Country? ŏ UNITED STATES 21157 102 TIMBER RIDGE DRIVE 238 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1X)Yes 2 □ No IfYes, Give Year or Dates: KOREAN 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify. 3 ₩ Widowed 4 Divorced WHITE natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BOOK ENGINEER PRINTING 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be inent of Health and Mental in it is marked o DORA WARD THEODORE HENRY SCHLOTTENMEIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 2015 BONHILL DRIVE, REISTERSTOWN, MD CAROL A. BROWN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State artment of h crtent: If its njury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL CEMETERY 7/21/04 BALTIMORE, MD permit.
Departmingorte any nju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A.
91 WILLIS STREET, WESTMINSTER, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a peach line. Approximate Interval Between Onset and Death Immediate Cause (Final Observe **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has certificate ha 1 Yes 2 1th 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 40 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours aft

To the Funerel Di

completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 116104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westruntun Unoll Hospita 2000 Remolis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JUL 2 6 2604

U4-04652 LANE SPITZER WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 Year **Physician** JULY 16, 5:34 PM Lane Bryant Spitzer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MEMORIAL HOSPITAL **CUMBERLAND** ALLEGANY CO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Year) Hours M 2□ F Yrs 7/29/99 Director 233-47-1594 WV Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits the Medical Examiner must be notified at tō 1 ☐ Yes 2 No or 28e-f Hardy Mathias Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Items 23e 198 Clearview Dr. 26812 death **USA** Funeral 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is and 2 should be fill Health and Mental H tem 27 is marked ott ၉ Gregory S. Spitzer April Dawn Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 is or othar tra April Dawn Miller (Mother) P.O. Box 352 Robinson Creek, Ky 41560 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pagas 1 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) parmit. Paga:
Department or
Important: If i any injury or once. ö Cedar Hill Cemetery 7/20/04 Mathias, WV 22. Name and Address of Facility McKee Funeral Home LLC 21 Signature of Funeral Service Licers P.O. Box 39 Baker, WV 26801 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 140 DO DND VECIL DISUME disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Cher (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?/
1 □ 4 as 2 □ No autopsy performed? 1 Yes 2□No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Diractor: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation OCCUPANT IN AU ATV, ETECHED 4:12 P 1 Yes 2 No 7-16-04 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6276 PAZKER HOLLOW RD, BAKER, WEST RODINMA 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) *CMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signarare and title of certifier 29d. Date signed (Month, Day, Year) OCME JULY 17, 2004 Youll MW) Whomas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MMY Drum

31. Date filed (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201 17 ·KORFU 32. Registrar's Signature ... Registrar

	1	For State Registrar	State of Maryland		artment of H			giene	004	23510
Physicia /Medica Examine	n al	David Lee Tucker David not institution, give s			4b. City, Town, or	Location of De	2. Date of Dea Month July	Day 6	Yeer 2004 punty of Deeth	3. Time of Death 4:30 P M
Funeral Director		609 Oakland Hill 5. Social Security Number 213-38-0654 6. Sex			Arno	old If Under 24 H Hours M		A (13, 1	Cou	undel place (State or Foreign aryland
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For	State of Maryland / Department of Health and Mental	Hygiene	
State Registrar	Certificate of Death	Reg. NG 0 0 4	2351

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5. 1°	f Hez itam othe		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla	(ce)	Date	20c. Location	n - City or	Town, State
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Baltimore,			21. Signature of Funeral Service Lic		7 4 4	22. Name and Addre		apitol N			•
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	attending for use as	/We	IF FEMALE:	23c. If yes, outcom	e of pregnancy				23d I	Date of deli	iverv
Box auth cert	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 ☐ Fetal death at time of death	3 Ectopic pregnanc 5 Other (specify)	·y		100	onth den	Day Year
o a	0 0	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9☐ Unknown	at time of death	J Ciriai (specify)					
. ф	ed by detac	Ph	Part II. Other significant conditions	contributing to doub	but not reculting in th	a undarbing cause au	von in Part I	23e Did to	Dacco use co	ntribute to	the cause of death?
Se Se	igne be d	by	Part II. Other significant conditions	contributing to death	but not resulting in ti	e underlying cause gr	VOITHEF OUT.				obably 4 □Unknown
ecords, P	been si	ted	1 ☐ Yes 2 💆 No 3 ☐ Pro							Ocaciy 4 DOTK/OW	
eCC awr	as be 2 sh	ple						24a. Was a). Were au	topsy findings available completion of cause of
Vital Record	ية ۾	Completed						perform	med? 2 □ No	death?	2□ No
ital an:	certificate rector, pag	a)	25. Was case referred to medical				26. Place of Death	, , _ ,			
f Vita ysician:	is cer direct	0	examiner? 1X Yes 2 □ No	Hospital:	tient 2 ER/Outpa	tient 3 DOA Ot	hor	me 5 Reside		ther (Spec	cify)

To the Hospital or Attanding Physimihin 24 hours after death.

To the Funaral Director: After this completely filled in by the funeral dire Division of Certification; Medical

28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

O.C.M.E.

29d. Date signed (Month, Day, Year) 29c. License number

JULY 5,2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZMBIULLAH

111 Penn Street, Baltimore, Maryland 21201

Registrar

31. Date filed (Month, Day, Year)

JUL 0 8 2004

		•	State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. 0 4 2 3 5 1 3
			1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death
	Physici		RAIDH I THOISE 355 PM
>	/Medic Examir	4.	1910-11-11-11-11-11-11-11-11-11-11-11-11-1
	CAGIIII	iei	4a. Equility Name (Il not institution, give street and number) Home 4b. City, Town, or Location of Death 4c. County of Deeth
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. 8. Date of Birth 9. Birthplece (State or Foreign
4.5	Director		224-22-8918
	p ,		Usual Residence of Decedent
	arylar thow	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No
	Sa-f	Director	Maryland Carroll Mount Airy
	vith th	Die	10e, Street and Number 10f. Zip Code 10g. Citizen of What Country?
	s 23s	ral	4101 Baltimore National Pike 21771 U.S.A. 11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian.
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-1 show event, the Medical Examine rineal be rudified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Married 4 Married 4 Married 5 Married 5 Married 6 Married 7 Married 8 Married 8 Married 8 Married 9 Married
21215-0036	thou sture	ed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
15	n "nat	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Give kind of work done during most of working life. DO NOT use retired)
212	swithin giene. r than "	E	10 Farmer Farming
	be filed tal Hygi d other	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
<u>lar</u>		<u>0</u>	Albert Sidney Tabler, Sr. Eve E. Care
Maryland	2 should be and Mental is marked c		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	2 = 2 I		Mary Jane Tabler - Daughter 823 Apache Court, Frederick, Maryland 21701
Baltimore,			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Ĕ	Pages nent of h ant: If its ary or o		Ya Donation 5 Other (Specify) Providence Meth. Cem. 7/13/04 Kemptown, Maryland
at	permit, Page Department of Important: If any injury of		21. Signature of Fundral Service Licenses () 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home
<u> </u>	897 29		Tovert L. Williams 26401 Ridge Road, Damascus, Maryland 20872
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition Onset and Death VICPY S17/1/1
As .	/Medical		resulting in death) Due to (or as a consequence of)
**************************************	Examiner		Sequentially list conditions. Ceremon Machine Account MACCOUNT MAC
	sit sit	iner	if any, leading to immediate Unit to (or as a consequence of).
	and and I-tran	Examin	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
8760,	death certificate be executed to attending physician and of for use as the burial-transit		
87	phys the	dicai	d
9 X	ding se as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
Вох	eath certific attending p	Physician/Me	in the past 12 months? 1 Live birth 2 Fedal death 3 Lectopic pregnancy Month Day Year
o.	by the detached	ıysi	1 Ses 2 No 9 Unknown 9 Unknown
Ω.	es tha igned be de	þ	Part II/Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown
orc	w requir been s should	eted	
of Vital Records,	The tar ate has page 2	Completed	24a. Was an autopsy findings available autopsy performed death? 1 Yes 20 No 1 Yes 20 No
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Other: Other: Other:
of	Phys this al dii	2	1 Inpatient 2 EHOutpatient 3 DOA 4 Jursing Home 5 Residence 6 Other (Specify)
	After uner	on:	27. Manner of Death 28a. Date of Injury Natural 5 Pending 28b. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Value of Injury 28b. Time of Injury at Work?
Sic	Attending or death.	cat	2 Accident investigation 3 Suicide 6 Could not be determined determined
Division	after after Direction by	ertificati	4 Homicide determined building, etc. (Specify)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) We Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. We Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. We dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year)
	- > PP 0		Melm J (mdm MM) 206388 7,1964
	11		30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print)
	7		31. Date filed (Month, Day, Year) 32. Registrar's Signature
4	Sta Regist		III 1 3 2004 Deneva & Spark

ORIGINAL

I	3		1 - For State Registrar		of Maryla		artment of I			R	leg. No. U	4 23	3514
	Physici /Medic	al	Decedent's Name (First, Mide Viola Cecelia Aa. Facility Name (If not institution)	Twigg	(aumhor)		4h City Town	v l agetion		Jul 19, 2	Day	Year 6:3	Time of Death 5 pm M
	Examin	er	St. Vincent de	-			Frostbu		of Death		Allega		
	Funeral Director		5. Social Security Number 213-22-4433	6. Sex 1 □ M 2 □		rs. la <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days		24 Hrs. g	Mar 20), 1915		State or Foreign
proland	show	L,	Usual Residence of Decedent 10a. State 10b. Coun MD AII	egany	10c.	City, Town or Lo	aptown						side City Limits
M ed	289-1 Dolliffe	Director	10e. Street and Number				10f. Zip Code			1	10g. Citizen of W		∏Yes 2∏No
tiw dib	23a or	al Di	14808 Forest	View Driv	e SW			2150	2		-	SA	
d 21215-0036 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23s or 28e-1 show any injury or other traumatic event, its Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed	Decedent Ever in d Forces? es 2 No , Give or Dates:		Was Decedent of In Yes, specify Cub	lispanic Ori an, Mexicar Specify:		ify Yes or No- can, etc.)	14. Race Black Specify:	e - American Ind k, White, etc.	ian,
)	n "natur Medical	Completed		ent's Education est grade complete	ed) je (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during mos	t of working	7	16b. Kind of Bu	siness/Industry	
	Hygiene other the ent, Ine	Com	12		Je (1-401 5+)	spinni	ng dept.	40.34-15	-1-21		textile		
Maryland 21215-0036	Mental H arked ott atic even	To Be	17. Father's Name (First, Middle John Skelle	y				Ma	ry Ch	ilcote S			
Mar	th and 27 is m traum		19a. Informant's Name/Relation James Twigg	iship (Type, Print)	son		ng Address <i>(Street</i> 20 Brant		er or Rural I		r, City or Town, : perland		21502
ore, r	of Health fitem 27 r other tr		20a. Method of Disposition 1 Surial 2 Cremation	0		p. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ce)	Dat		20c. Location -		
Baitimore,	Department of months of mo		*4 □Donation 5 □ Other	(Specify)	S S	t. Mary's (1		//22/2004	Cullibe	erland	MD
ng i	Depar Impor any in		21. Signature of Funeral Service	7	a not	10.	2. Name and Addre Scarpe	iss of Facilit	ral Hor	me, P.A.			
			23a. Part V Enter the disease, shock, or heart failure. Li	or complications th	at caused the de	eath. Do not en	108 Vir ter the mode of dyi	ginia A ng, such as	venue; cardiac or i	Cumber respiratory arr	land, MD	21502 Appro	oximate val Between
ρ	nysiolan	7	disease or condition	a a	acut	Num	e Fril	und				Onse	and Death
	/Medical xaminer		resulting in death)	Due	to (or as a cons	equence of):	l Fail Renne	n .				7.00	
	THE	Jer	Sequentially list conditions, if any, leading to immediate	b. Due	To (or as a cons	equence of):	June	Vige	est			ye	2 S
ate be executed	ohysicien and the burial-transit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									
ate be ex	icien a burial-	icai Ex	resulting in death) Last	Due	to (or as a cons	equence of):							
DO /	g phys as the	0		d									
BOX Bath cart	ettending pt d for use as t	an/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pred		Dectopic pregnanc	V				of delivery	Wass
I Records, P.O. Box 68 The law requires that the death certific	ed by the ettendin detached for use	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		regnant at time o nknown	f death 5	Other (specify)				Mon	ith Day	Year
7. ied	ned by	by Ph	Part II. Other significant condi	tions contributing t	to death but not i	resulting in the u	nderlying cause gr	en in Part I		23e. Did to	bacco use contri	bute to the caus	se of death?
ords	been signed I		Conna	y sonte	ing o	send	, h			1 🗆 Y	es 2□No	3 Probably	4 Sukknown
ie co	has be je 2 sh	Completed	Dorle	ites u	rule to	2				24a. Was a autops	sy p	Vere autopsy fin	
ים בים בים בים	ficete or, pag	e Cor	25. Was case referred to medic	and the same of th				00 81	-4 D45 /	perform	2 21N o 1	eath?	0
r VII	is cert	OB	examiner?	Hospital:	☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ott				<i>ence</i> 6 □Othe	r (Specify)	
	h. After th funeral	tion: T	27. Manner of Death	ling (A	ate of Injury Month, Day Year,	28b. Time o Injury	Wo		28		ow injury occurre		
DIVISION OF VITAL RECORDS, or Attending Physician: The law requires:	within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 □ Coul	d not be 28e. P	lace of Injury - A uilding, etc. (Spe	t home, farm, str ecify)	reet, factory, office			f. Location (Si City or Town	treet and Numbe n. State)	er or Rural Route	Number,
Hospite	24 hours Funeral	edical C	29a. Certifier Tourify (Check only one) 2 Medica	ing Physician: To al Examiner: On the	the best of my less than the basis of examination of the basis of examination of the basis of th	knowledge, deat ination and/or in	h occurred at the ti vestigation, in my o	me, date an opinion, dea	d place, and th occurred	d due to the c	ause(s) and mar late and place, a	nner as stated. nd due to the ca	1US8(S)
Tothe	within To the comple	Med	29b. Signature and title of certif		and design		29c. Licens	se number		2	9d. Date signed	(Month, Day, Y	ear)
,				an	2		200	2124	14		7/2	0/200.	4
			30. Name and address of person								•		
	Sta	te	Jesus Tan M	J , D . 3	2. Registrar's Sig	Fros	tburg Plaz	a Fro	stburg	MD 21	1532		
	Registr		JUI 2	6 2004	Dener	0	spark	2					

If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an

autopsy 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

8:08 A.M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other:

4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

25. Was case referred to medical examiner?

5 Pending investigation 3 Suicide

6 ☐ Could not be determined

Hospital:

1 Supatient 2 ER/Outpatient 3 DOA te of Injury (Month, Day Year) Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c 1 ☐ Yes 2 ☐ No

🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

4 Homicide

IF FEMALE

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 No

and manner stated. 29c. License number

29d, Date signed (Month, Dav. Year)

29b. Signature and title

who completed cause of death (Item 23a) (Type, Print

7 0

30. Name and address of perse

JUL

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year) 2004 0 9

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should be

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certificate has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified

a Funerail

within 2

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Completed

Be

2

Certification:

Medical

Division of Vital Records,

			1 - For State Registrar	State of Maryland		artment of I		d Mental H	ygier Reg. 1	2001	2351	6
	Now To	31	Decedent's Name (First, Middle, Last,					2. Date of I		Na	3. Time of Deat	h
	Physici /Medic		William A. Wa	atkins Jr.				July		оау Үеа 004	3:00 g	M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of De	ath		c. County of De	ath	
		變	119 J Warwicksh			Glen B				Anne A		
¥	Funeral		5. Social Security Number 6. Sec	F	ist birthday) Yrs.	If Under 1 Year Months Days		in. (Month,	Day, Yea	ar)	lirthplace (State or Ford Country)	eign
	Director		217-56-4245 Usual Residence of Decedent	^{8∟M 2} □ F 53	113.			June	23	1951 M	aryland	
	land ow		10a. State 10b. County	10c. City	Town or Lo	cation					10d. Inside City Lin	nits
	Many	ţō	Maryland Anne A	rundel Gle	n Bui	cnie					1 X Yes 2 □	No
	r 28e	Directo	10e. Street and Number	rander Ore	II Dai	10f. Zip Code			10g.	Citizen of What	Country?	
	th wit		119 J Warwicks	hire Lane		2106	1			USA		
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of I	Hispanic Origin? an, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	No-	14. Race - Ar Black, Wi	nerican Indian, nite, etc.	
36	hours after death with the Maryland tural', or Items 23a or 28e-f show at Examinat must be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes Z∰So If Yes, Give		1□Yes 2昼No	Specify:			Specify:	Black	
Ö	be filed within 72 hours after death with the Marylan ital Hygiene. id other than "netural", or litems 23a or 28e-f show event, the Medical Examinat must be notified at	q pa	3類Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual Occu	nation		16h	Kind of Busines	es/Industry	
7	within 72 ene. than "net	Completed	(Specify only highest grad	e completed)	(Give	kind of work done DO NOT use retire	during most of v	vorking	100.	Kind of Busines	samuatry	
212	iene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	FO	od Serv	ice		Н	ardees	Restaura	int
ַ	e filed wit Il Hygien other th	Be C	17. Father's Name (First, Middle, Last)					lame (First, Midd				
<u>a</u>	Aental Aental rked o	ToB	William A.	Watkins Sr.			Не	elen L.	Ga	11oway		
Maryland 21215-0036	2 should be and Mental is marked (eumatic ev		19a. Informant's Name/Relationship (T)			ng Address (Street						
Σ.	and sealth im 27 in the tre		Tony A. Watkins				rest Av		_		. 21225	
ltimore,	of Fite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ F	Compared from State	metery, crei	sition (Name of matory or other pla	(CO)	Date		Location - City		
Ē	Pages iment of tant: If its jury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	Me		Cremato		/8/04	Ba	ltimor	e, Ma.	
Ball	permit. Pag Department Important:: I any injury o		21. Signature of Funeral Service Licens	99	1	Name and Address Ree	se & Sc	ons MOr	tua	rv, P.	Α.	
	402 a 0		Lavy Sing	Ese 1100483		321 Wes	t St. A	Annapol	is,	Md. 2	1401 Approximate	
			23a. Part1. Enter the disease, or complessors, or heart failure. List only o	ne cause on each line.	Do not ent	er the mode of dy	ng, such as card	iac or respiratory	arrest,		Interval Between Onset and Death	ì
*	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	lung		mur						
0	Examiner		1	Due to (or as a consequ	ence of):						2 Month	ng
4		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):							
	uted 1 Insit	Examiner	Cause (Disease or injury									
Ć.	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):							
8760	ate be executed hysician and the burial-transit	dicai		d								
Ó		Medi	IS SCHALE.									
Вох	death certific e attending p id for use as	Physician/Me	230. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	:y			23d. Date of o	lelivery Day Year	
0.	at the dea by the at tached fo	Sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown	ath 5□	Other (specify)				Month	Day 16a1	
<u>Ч</u>	The law requires that the tee has been signed by thoage 2 should be detached.	Phy	Part II. Other significant conditions co	atributing to death but not requi	ting in the u	ndarhina cauca a	von in Part I	23a Di	d tobacc	a use contribute	to the cause of death?	,
JS,	ires ti signe d be c	by	Farm. Other significant conditions co	intibuting to death but not resu	ung in trie u	nderlying cause gi	veilii Faiti.		⊒ Yes		Probably 4 Unkno	
0.0	w require been si should t	eted					-	-		1		
Vital Record	e law has t	Completed						24a. Wi - au	as an topsy rformed?	24b. Were prior to death	autopsy findings availa o completion of cause ?	of
a								1 ☐ Yes	2 🖃		es 2 No	
₹	Attending Physicien: r death. sctor: After this certifica	Be C	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	D/O	ot post of	had	eath (Check of		a = 0.00 (0.		-
ō	ding Phy n. After this funeral d	To To	27. Manner of Death	28a. Date of Injury	P/Outpatier 28b. Time of			Home 5 Re		jury occurred	Decity)	
on	nding th. :: Afte	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	lnju ry		ork?]Yes 2 □ No					
Division of	or Attendate death Director:	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, str	eet, factory, office	-	28f. Location	(Street	and Number or	Rural Route Number,	
	s after el Dire	Certification:	- Indinibido	building, otc. (opeany)				Only G	OM1, 31	10)		
	To the Hospitel or All within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati	rledge, death	occurred at the t	me, date and pla	ice, and due to th	e cause	(s) and manner	as stated.	
	To the H within 24 To the F complete	ledi	one)	and manner stated.								
	To the vithin To the comple	Σ	29b. Signature and title of certifier	Man a		29c. Licen	se number	5	29d. [Date signed (Mo.	ntn, Day, Year)	
			70000	ン)			2 120	<u> </u>	٦	my 6,	2007	
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type,	Print Dr.	Glen	Burn	10.	MD.	21061	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signate		•	-				- 1	
	Regist		JUL 0 8	2004	A	1 00						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Ju₁y 2004 3:45p Μ. We1ch Annie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2X F Yrs. 224-09-6298 89 9, 1915 Director Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28e-1 show eny injury or other traumatic event, the Medical Event. 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No Glenn Dale Maryland Prince George Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9910 Dubarry Street 20769 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify þ Black 3 € Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker 11 Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eddie Figgs Daisy Walker ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Gilchrist/daughter 9910 Dubarry St., Glenn Dale, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Cocation - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Carver Cemetery Suffolk, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Mariboro Pike, Forestville, 20747 elle Approximate Interval Between Onset and Death 23a. Part 1. Enter the Jissue, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fedure. List only in cause on each line. Immediate Cause (Final Interne Fin ocardial. **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner orona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner didinacula The law requires that the death certificate be executed burial-transi Athonsolono and Due to (or as a consequence of): P.O. Box 68760. the attending physician Diaboles Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor i in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed Division of Vital Records, Be Completed by page 2 should be Lschemi 2 10 No 3 Probably 4 Unknown 1 Tyes Locho mue 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Chrones 1 ☐ Yes 2 ☐ No certificate 1□ Yes 2DM6 filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely i e 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cq 47867 person who impleted cause of death (Item 23a) (Type, Print) 30. Name and addresses Oney Zuniga, 4701 Randolph Road #701, Rockville, MD 31. Date filed (Month, Day. 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	-	epartme Certifica				Re	g. No.2	001	23518
	Physicia	an	Decedent's Name (First, Middle, La.	•					2	. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic		Alphonso V	Villis					J	une 2	Day 20	004	2345 M
	Examin		4a. Facility Name (If not institution, give					r Location of			46. Co	unty of Death	
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L	Funeral Director		3/9-/0-3693	GAA OF	e (In yrs. last birt	Yrs. If Und	ler 1 Year s Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, 10 31	Year) 1951		plece (State or Foreign ntry) ington,DC
	and *	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene. dether than "natural", or items 23a or 28a-f show adother than "natural", or items 23a or 28a-f show event, the Medical Ezari iner innet be notified at	ō	100		0:1	0.1							1 Yes 2 □ No
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	er de Item	nu	11. Marital Status 1★ Never Married 2 Married	Armed Forces?		If Yes, s	pecify Cuba	an, Mexican,	, Puerto Rio	can, etc.)	1.4	Black, White,	
36	rs aft		3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	10	1 🗆 Yes	2 No	Specify:			Sp	pecify: B1	ack
21215-0036	hou fura	Completed by	15. Decedent's Ed		16a.	Decedent's U	sual Occup	ation			16b Kind	of Business/In	ndustry
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9	filed Hygir ther ant,		17. Father's Name (First, Middle, Last,					18. Mother	r's Name (F	First, Middle, N			
an	Mental Merked o	o Be	Almon Will	is				V	irgin	nia Br	im		
2	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the M	ဥ	19a. Informant's Name/Relationship (19b.	Mailing Addre	ss (Street			Route Number,		own State Zir	Code)
Maryland	S as as		Virginia Willis/			_					-		DC 20002
	item 27		20a. Method of Disposition	Hother	20b. Place of cemeter				Date	- D		tion - City or To	
Baltimore,	permit. Pages Department of I Important: If its ony injury or o		1 Burial 2 Cremation 3						10.100				
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	40100		<u> </u>	-line since a sheet and a	t the death Dea					andove		ryrand	Approximate
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P.O. Box 6	at the death certifice by the attending pt tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic 5 □ Other					230	. Date of delive Month	ery Day Year
ر .	The law requires that the ate has been signed by th page 2 should be detache	by Pi	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlyin	cause giv	en in Part I.		23e. Did tob	acco use	contribute to t	he cause of death?
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of	Physician: r this certific ral director,	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 A Inpatie	ont 2 ER/Out		28c. Injur	4 🗌 Nurs		5 Reside			(y)
		<u>lo</u>	1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) Ir	njury M	Wor	k? Yes 2.⊟N		1. Describe no	w inquity of	Carred	
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Ì		ij	4 Homicide determined	building, et	ury - At home, fai c. <i>(Specify)</i>	iiii, siieei, iaci	ory, onice		201	City or Town		umber or nura	ar Houle Namber,
	Hospita 24 hours Funeral	edical Ce	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner sta	t examination and	, death occurr d/or investigati	ed at the tin	ne, date and pinion, death	place, and	due to the ca at the time, da	use(s) and pla	d manner as s	tated. o the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	81101)		9c. Licens		1 1	29		igned (Month,	
				rvss	1-		DH	541	471		6	-30-	04
			30. Name and address of person who	ompleted cause of d	leath (Item 23a) (Type, Print)							
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	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	,							

			1 - For State Registrar	State of Maryland / Depa	artment of Health and I	Mental Hygien	
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Da	
	/Medic	al	JOHN RAY 4a. Facility Name (If not institution, give s	WOLFE	4b. City, Town, or Location of Death	JULY 1	1 2004 1:28A M
	Examin	er	FORT WASHINGTON		FORT WASHINGTO		PRINCE GEORGE'S
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	Birthplace (State or Foreign Country)
	Director		216-12-4123 2	87 Yrs.		NOV.13,19	916 MARYLAND
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation	***	10d. Inside City Limits
	Ba-f s	ctor		EORGE'S SUITLANI			1 ☐ Yes 2X No
	with the	Dire	10e. Street and Number 3418 ABERDEEN S	STREET	10f. Zip Code 20746	10g. C	itizen of What Country? U. S. A.
	death	Funeral Director		12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,
98	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show evant, I're Madical Examiliar ruint te indifficial at	y Fu	1 Never Married 2 Married	Yes 2 No	1 1 Yes 2 □ No Specify:	o rican, etc.)	Specify:
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and	d be fill ad oth	Be c	17. Father's Name (First, Middle, Last) JOHN LOCKE WOLF	ידי	HELEN	ne (First, Middle, Maide CROSS	n Sumame)
Maryland	should be ind Mental Ind markad o	To	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Maili	ng Address (Street and Number or Ru		or Town, State, Zip Code)
	alth a		ALICE HELEN WOL				MARYLAND 20746
altimore,	Pages 1 are neut of Hearint: If item		20a. Method of Disposition 1 Disposition 2 □ Cremation 3 □ P	temoval from State		10,	Location - City or Town, State
Itim	Territ .		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens				LDORF, MARYLAND
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Вох	Jeath certific attending pl	M/U	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery
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Division	after death after death Diractor: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st. building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
	spita ours naral fille		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, deat	h occurred at the time, date and place	, and due to the cause(s) and manner as stated.
	To the Hospital within 24 hours a To the Funaral I completely filled	edical	(Check only 2 Medical Exami	ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date ar	id place, and due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	10.0	29c. License number		ate signed (Month, Day, Year)
			Nama	~ MIJ	00055120	1 1	My 12,2004
1	15/12	11	30. Name and address of person who co	ompleted cause of death (Item 23a) (Type, 13 2 & Southern Avenue S	E Sante 310 wahing	ton Dc 20032	
	Sta	ate	21 Data filed (Marth Car Vara)	2004 32. Redistrar's Signature	Societies		
	Regist	rar		The state of the			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6 **Physician** THELMA RICKETTS WILSON 6:42A M 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth Examiner CHESTERTOWN KENT Chestertown Nursing & Rehab. Birthplece (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 02 9 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 20F 90 Yrs. 557-60-7130 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Nes 2 No Directo CHESTERTOWN MD KENT 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21620 USA 225 W Calvert St Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATOR** TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERMAN RICKETTS CELIA UNKNOWN permit. Pages 1 and 2 shoul Department of Health and Mi Important: If Item 27 is marf any injury or other traumath 90029. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DOLORES WILSON-DAUGHTER 222 Calvert St Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 6/28/04 Chestertown, MD Janes U. M. CEME. ' 4 □ Donation 5 □ Other (Specify). 22. Name and Address of Facility Kenneth Walley Funeral 21. Signal re of Funeral Service Licens (W00026) Service 821 W St Annapolis, MD 21401 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or meant failure. List only one cause on each line. Approximate Interval Between Onset and Death Al Cerebrovascu I mediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? II. Other significent conditions contributing to death but not resulting in the runderlying cause given in Part I. þ (andioro ala 2 No 3 Probably 4 □Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? раде 2 No 2 No 1 Yes 1 TYes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Xio Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deals To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗀 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatute and title of certifier 29c. License number 17036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 Washington Ave Chestertown, Maryland 21620 Susan Ross MD 31. Date filed (Month, Day UN) 2 8 200 4. Regimer's Signature State Registrar

DHMH 17 Rev 1/2001

with the Maryland

within 72 hours after

should be f and Mental h

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event. If a Medical Examinar Loust be notified at

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After or Attending

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P.O. Box 68760,

Division of Vital Records,

	4	For State	State of Ma	ryland /				lental Hy	giene)	
		Registrar 1. Decedent's Name (First, Middle, Las			Cer	tificate of L	Jeam	2. Date of De	Reg. No.	2004	3. Time of Beath
Physicia	_							Month July	Day 3	2004	
/Medica Examine		Nancy S. 4a. Facility Name (If not institution, give	Wetzel street and number)			4b. City, Town, or	Location of Death	July		. County of Dea	
Examine		Chestertown N	ursing &	Reha	b	Cheste	ertown]	Kent	
Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Bi	rthplace (State or Foreign country)
Director		186-14-7851	□M 2 X F	80	Yrs.			Feb 1	0 19	924 Pei	nnsylvania
and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
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r 28a	Jec.	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What C	Country?
h with	Funeral Director	315 Rosin Dr.				2162				S.A.	
eme ere	le l	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Wh	
S afte	Dy L	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	0		1□Yes 2XINo	Specify:			Specify:	White
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Healtl	1	Andy Wetzel 20a. Method of Disposition	(son)	20b. Place	of Dispo	Box 18 sition (Name of		rch Hi		ocation - City o	
ages intof triffit		1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			-	matory or other place emation		/04	Sm	yrna,	DE.
perillinore, Mari yiani with Inc. 12-10-00 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be inclifted at once.		21. Signature of Fun ral Service Live	199		G ²²	Name and Address	ss of Facility	Home o			L. Schaec
n goraa		23a. Part 1. Enter the disease, or com		100510) [1]	18 West	Cross S	St. G	aler	na, MD	21635 Approximate
		shock of heart failure. List only	one cause on each lin	e.	O HOL BHI	er the mode of dying	g, such as cardiac	or respiratory a	111031,		Interval Between Onset and Death
Physician /Medical		Immediate Causé (Final disease or condition resulting in death)	a	dario	<u>~</u>						6 days
Examiner			Due to (or as a	Consequenc		e menti	A				3 ur.
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	L consequenc							
cuted	Examin	cause (Disease or injury that initiated events	c								
ficate be executed physician and is the burial-transit		resulting in death) Last	Due to (or as a	a consequenc	e of):						
& f oU,	dical		d	 							
X Se as	0	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d. Date of d	elivery
death certifice attending to do to use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal dea		Ectopic pregnancy Other (specify)				Month	Day Year
. 0 0 0	nysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown								
	by P	Part II. Other significant conditions					en in Part I.	23e. Did	tobacco		to the cause of death?
cords, w requires t been signe should be	ed	Mypothyroin,	ASCAR) Hu	gre-	rejan		1 🗆	Yes 2	200 3□1	Probably 4 Unknown
law re as be	Completed	Cerebrovascul	as accord	ent				24a. Was	psy	prior to	autopsy findings available completion of cause of
The The page	Con							1 ☐ Yes	ormed?	death?	
VITAI KEC sician: The law certificate has t irector, page 2 s	Be	25. Was case reterred to medical examiner?	Hospital:			Oth	26. Place of Dea				
₩ ₹ ∰ F	2	1 Yes 20 No 27, Manner of Death	1 ☐ Inpatie	nt 2 ER/6	Outpatie	IT 3L DOA	Nursing ri	ome 5 Res			ecify)
E & 95	tion	1 Accident 5 Pending investigation	(Month, Day	Year)	Injury		k? Yes 2 □ No				
DIVISION I or Attending after death. Director: After	ifica	3 Suicide 6 Could not be determined		iry - At home,	, farm, st	reet, factory, office		28f. Location City or To	(Street al	nd Number or i	Rural Route Number,
tel or s afte el Dir	Certification:	4 Notificide	building, etc	(Opecny)				,			
DIVISION To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: At completely filled in by the fu	Medical	29a. Certifier Check only one) Certifying P	hysician: To the best of miner: On the basis of and manner sta	examination	dge, deat and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	, and due to the rred at the time	cause(s , date an	and manner of place, and di	as stated. ue to the cause(s)
o the	Me	29b. Signature and title of certifles				29c. Licens			29d. Da	1 2	nth, Day, Year)
⊢ s ⊢ ō		1 Ad	(WO		Di	51735		1	/3loi	†
		30. Name and address of person who	completed cause of d	eath (Item 23	а) (Туре	Print)					
		Frederick Del	boy, M.D	. 6	602	Church	Hill Ro	d. Che	stei	rtown,	MD. 21620
Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	K	South					
Registra	al	JUL 0 (LUUT JU		4	The same of the sa					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert Sylvester Wallace Month Year July 3, 2004 М 0250 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 04/29/1923 Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□ F 81 Director Yrs. 215-26-3983 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov The Medical Examiner must be notified at 1√2 Yes 2 No Director Maryland Kent Millington 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 321 Cypress STreet 21651 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 27 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced WWIT 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 11 Production Control Supervisor | Manufactoring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be f Mental I is marked Harry Wallace Molly L. Dixon and 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum <u>once</u>. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wyatt K. Wallace/Son 283 Poplar Point Road, Perryville, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery 07/07/2004 Millington, Maryland 21. Signature Fysical Service Licensee Pellows, Helfenbein & Newnam Funeral Home, 370 W. Cypress Street, Millington, MD 21651 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart drilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) - NCep ha Physician /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical 25 signed by the attending the detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 3 Probably 4 Unknown should 1 🗌 Yes 2 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has prior to co death? 1 ☐ Yes of Vital Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2<u>™</u> No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1603 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 Speer RD Bolg. BChestertown mo 21620 Inoliew S Ferguson 31. Date filed (Month, Day Year) 6 2004 32. Re State Registrar

		•	For State Registrar	State of	Maryland		artment of H		nd Menta	l Hygier	2001	23523
			Decedent's Name (First, Midd.	lle, Last)		77.00			2. Date Mor	of Death	Day Year	3. Time of Death
П	Physicia /Medic		ETHEL N	MAE WOL	FE				JUI	Y 1	8 2004	6:45 A M
П	Examin		4a. Facility Name (If not institution				4b. City, Town, or		f Death		4c. County of Deatl	
			Frederick				Freder		A Hrs a Date		Frederi	
	Funeral		5. Social Security Number 214–16–1195	6. Sex 7	7. Age (In yrs. lasi 85	Yrs.	Months Days	Hours	Min. (Moi	of Birth oth, Day, Yea	1919 Mary	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		0.5				Jaii	. 13,	1717 Hal	/ Lanu
	yland yland		10a. State 10b. County	1	10c. City, T	own or Lo	cation					10d. Inside City Limits
	a-f s	ctor	Maryland Freder	ick	Freder	ick						1 ☐ Yes 2 X No
	or 28	Dire	10e. Street and Number				10f. Zip Code				Citizen of What Co	untry?
	ath w	ral	2108 Whitehall		dent Ever in U.S.	12	21702 Was Decedent of H	licagojo Orig	nin? (Specify Vo	USA	14. Race - Ame	ncan Indian
	item item	Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Ma	Armed For	ces?	13.	f Yes, specify Cuba	an, Mexican,	, Puerto Rican, e	etc.)	Black, White	
39	al', or	ρ	3 X Widowed 4 □ Divorce	If Yes, Give	e ites:		1 ☐ Yes 2 🎇 No	Specify:			Specify: Wh	ite
5-0036	within 72 hours after death with the Maryland ene. Then *naturel', or items 28s or 28s-f show he Medicul Evandrer must be notified at	Completed	15. Decede	ent's Education est grade completed)		16a. Dece	dent's Usual Occup	ation	of working	16b	. Kind of Business/	Industry
2121	ithln 7	nple	Elementary/Secondary (0-12)	College (1-		life.	DO NOT use retired	d)	3	P1		D 1 - 44
ณ	filed w Hygier other th		17. Father's Name (First, Middle	1		Assem	bly Worke		r's Name (First,			Production
and	ibe fi	Be	Lawrence A. Pea						rine B.			
2	should be land Mental I s marked o	၉	19a. Informant's Name/Relation			19b. Maili	ng Address (Street				ty or Town, State, Z	Tip Code)
<u>≅</u>	ad 2 s lith ar 27 is r trau		Ronald Pearl, 1		5	66 We	nner Driv	e, Br	unswick	, Mary	1and 21	716
re,	s 1 ar f Hea ltem othe		20a. Method of Disposition		20b. Plac		osition (Name of matory or other place		Date		. Location - City or	Town, State
Ë	Page nent o nt: If		1 X Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (et Cemete		/19/2004	4 Fr	ederick,	Maryland
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Inportent: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show amportent: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show ampring or other traumatic event, the Medical Exercition must be notified at once.		21. Signature of Funeral Service	DUGE				Basford Follows	uneral Home 21701			
			23a. Part1 En er the disease, of shock or heart failure. Lis	or complications that cast only one cause on e	aused the death.							Approximate Interval Between
П	Physician		Immediate Cause (Final disease or condition	ash	ern SCH	Pond	to Can	den	vascus	lan o	liseese	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequer	nce of):		Second .				
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	ed .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- Due to (or as a consequer	ice oi).						
	xecut and	xan	that initiated events resulting in death) Last	cDue to (or as a conseque	nce of):						
8760,	death certificate be executed attending physician and of for use as the burial-transit			d								
9	as as	ledi										
Вох	eath certific attending pl for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant		come of pregnanc		□Ectopic pregnancy	у			23d. Date of del Month	ivery Day Year
	that the death cer ed by the attendin detached for use	Physician/Medical	in the past 12 months? 1 Yes 2 No		ant at time of dea		Other (specify)		•		WOITH	Day
0.0	requires that the leen signed by th hould be detache		9 Unknown Part II. Other significant condit	tions contributing to de	eath but not resulti	ng in the u	ınderivina cause aıv	en in Part I.	23	e. Did tobacc	co use contribute to	the cause of death?
ds,	w requires that s been signed I should be det	d by	195teo p	proses	. Non	100	Tia			1 🗆 Yes	2 4NO 3 Pr	obably 4 Unknown
Sor	> 10 0	ete	Cal me	alle in	100	A	- 10		24	a. Was an	24b. Were au	itopsy findings available
Re	ha:	Completed	for my	aryea	rece	arro	acrec_			autopsy performed	prior to death?	completion of cause of
Vital Records,	icien: Th certificate rector, pag	a	25. Was case referred to medic	cal				26. Place	of Death (Chec	Yes 2 🖸 k only one)	110 1 11 185	2 NO
	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🖫 🗝 6	Hospital:	npatient 2 DEF	VOutpatie	nt 3□ DOA Oth	200			e 6 □Other (Spe	cify)
Jο	ding Phys		27. Manner of Death 1 □Natural 5 □ Pend	28a. Date of	of Injury 2 th, Day Year) 2	8b. Time o	of 28c. inju	ry at rk?	28d. De	scribe how in	njury occurred	
Siol	Attending r death. ector: After by the fune	catlo	2 Accident inves	stigation				Yes 2 □				
Division	or Attenates deatler deatlers birector:	Certification;		minord 286. Flace	of Injury - At hom ng, etc. (Specify)	e, farm, st	reet, factory, office		281. Loc Cit	y or Town, S	t and Number or Ru tate)	irai Houte Number,
	lospitel hours a uneral I		29a. Certifier 1 Certify	ying Physician: To the	hest of my knowl	edne dea	th occurred at the ti	me, date an	d place, and due	to the cause	e(s) and manner as	stated.
	a Hos 24 hc b Fun etely	dical	(Check only 2 Medics	al Examiner: On the ba	asis of examinationer stated.	n and/or ir	nvestigation, in my	opinion, deal	th occurred at th	e time, date	and place, and due	to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and tille of certif	iler /	. 11	/	29c. Licens	se number		29d.	Date signed (Mont	h, Day, Year)
			1/lli	Kler	walter	My	DD	351	183	•	7/18	104
			30. Name and address	on who con let a caus	se of death (Item 2	(Type	Print)	. 1	to as	1 6	10-	6 ms
			31. Date filod (Month, Day, Yea	MI 10	legistrar's Signatu	7 re	500 L	29		1/6	eatile	IL I'LL
	St Regist	ate rar		6 2004	Beneva	1	doors	2				
	The second second	7 35	JUL ~	W WUT		-	//					

			1 - For State Registrar	State of	Marylan			nt of H		and M	-	giene Reg. No.	200	1000	22521	
	Physici	an	Decedent's Name (First, Middle, Last								2. Date of De Month		Yea		Time of Death 11:45a ^M	7
	/Medic Examin		Mary Hadaway Zie 4a. Facility Name (If not institution, give		oer)		4b. Cit	y, Town, or	Location o	f Death	July		200 County of De		11:45a	
	LAdiiiii	ei S	Chestertown Nurs			itation	1	Chest	ertow	n			Kent			
	Funeral Director	877.	5. Social Security Number 6. S 216-07-6960	ex 7. □M 2□F	Age (In yrs. 89	last birthday) Yrs.	If Und Month	er 1 Year s Days	If Under a	Min.	8. Date of Bir (Month, Da Nov. 12	th ly, Year)		Birthplace Country)		7
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation							10d.	Inside City Limits	
	Maryli f sho	or	MD Kent			esterto									1 Yes 2 No	
	r 28a	rec	10e. Street and Number		GII	SLELL		ip Code				10g. Citi	zen of What	Country'	?	_
	23a o	ai D	200 Byford Drive	<u>:</u>				216	20			Į	JSA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Evarance must be notified at anone.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedd Armed Forc 1 ∐Yes 2 If Yes, Give Year or Date	es? □No			edent of Hi becify Cuba	ispanic Origin, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Ai Black, W Specify:			
Maryland 21215-0036	2 hours	ted t	15. Decedent's Ed	lucation		16a. Deced	lent's Us	ual Occupa	ation			16b. Ki	nd of Busine:			
215	hin 72	plet	(Specify only highest gra	de completed) College (1-4	or 5+)	(Give	kind of v	vork done d use retired	durina most	of working	g				•	
2	giene giene er the	Completed	11	OUTINGO (1 4		Book	kee	per				Ap	plian	ce D	ealer	
2	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)								(First, Middle,		,			
yla	Ment Marke	T _o	Mowbray Hadaway								e Eliza					_
Mar	12 sh hand 7 ie m Iraum		19a. Informant's Name/Relationship								Route Numbe				de)	
9	1 and Healt em 2		Joyce Ziesel/dau 20a. Method of Disposition	ignter	20b. P	lace of Dispo	sition (N	ame of			tertown		cation - City	or Town.	State	
Baltimore,	ages int of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specific		ate C	emetery, cren	natory of	other plac	'	7/10	10001					
	nit. P artme ortan injury		21. Signature of Funeral Service Liver		Cr	nester 22			S of Facility		/2004	Ches	terto	vn,	MD	-
Ba	Depa Impo Impo any i		* Kufot Hu	Lanbe	in		Fe1.	lows	Helfe	nbei	n & New nestert	mam	Funera	11 Ho 216	ome, P.A	•
**	S. A. C.		23a. Part1. Enter the disease, or cont shock, or heart failure. List only Immediate Cause (Final	plications that cau	h line.		er the m	ode of dyin	g, such as	cardiac or	respiratory a	rrest,		Ap Int	pproximate erval Between aset and Death	
ĝ.	Physician /Medical		disease or condition resulting in death)	a. Due to los	as a consequence	103 cla	zen!	Ca	ndio	V do co	elar (150	62	+7	1 years	
W	Examiner				as a consequ	uonos on.										
	cuted of ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a conseq	uence of):										
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9	tificati ig phy as the	ledic		· · · · · · · · · · · · · · · · · · ·												
O. Box	0 0 T	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2∏Feta nt at time of d	Ideath 3	lEctopic Other (pregnancy specify)				2	23d. Date of o Month	lelivery Day	y Year	
م	that the	Ph)	Part II. Other significant conditions of	ontributing to dea	th but not res	ulting in the ur	nderlying	cause give	en in Part I.	-	23e. Did to	obacco u	se contribute	to the c	ause of death?	٦
ords,	w requires that been signed I should be det	ted by	Diabets m	rellitus							10'	∕es 2/0	€No 3□	Probably	/ 4 □Unknown	
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ξ	Physician: this certificatal director, i	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	patient 2	ER/Outpatien		Othe	· V		(Check only only only only only only only only					-
n of	ing Phy After this uneral d	lon; To	27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of (Month,		28b. Time of Injury		28c. Injury Work	at	2	8d. Describe I			овспу)		-
Division of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place o	f Injury - At ho	ome, farm, stre	M eet, facto		Yes 2□N		8f. Location (S City or Tox	Street and	d Number or	Rural Ro	oute Number,	
Ω	pital cours af eral D		29a. Certifier 1 Certifying Ph	valcing. To the b	att of the least	utata tan	- Section 180	d as the time	us date are	t slane o	of this terms	encontrat	and -area		4	
	e Fun	edical	(Check only 2 Medical Exam	niner: On the bas and manne	is of examina	tion and/or inv	estigation	on, in my op	pinion, deat	h occurre	d at the time,	date and	place, and d	ue to the	a. cause(s)	ï
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and title of certifier	1 1			2	9c. License	number			29d. Dat	signed (Mo	nth, Day	, Year)	_
•			> Jone V	Mos	> h5.	\rightarrow		D1.	763	6		7	18/04			
			30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print)	10	^^	1	/		-1-1	-3.3		
			1 10000	mD	5160	Washin	rator	toe	_ Cl	estre	town 1	nd o	21626	3		11
	Sta Registi		31. Date filed (Month, Day, Year) JUL 0		jistrar's Signa		do	10 PM								

			. 10400	State of M	larvlan						ental Hv		Legible.	
			1 - For State Registrar	Otate of IV	iai y iai i		tificate			and w	_	Rag. No	1000	22525
			Decedent's Name (First, Middle, Last	t)				0. 2			2. Date of De	ath		3. Time of Death
	Physicia		Toribio Ocaba A	had							Month July	24	y Year 2004	3:05 PM
	/Medic Examin		4a. Facility Name (If not institution, give)		4b. City,	Town, or	Location o	f Death	oury		. County of Death	
			Harford Memorial	Hospital			Havr	e de	e Grac	ce			Harford	
	Funeral		5. Social Security Number 6. S			ast birthday)	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year	9. Birth	place (State or Foreign intry)
	Director		213-39-7003	M ZUF	8	4 Yrs.							1920 Phi	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Maryl f sho	ō	Maryland Harford		Ab	ingdon								1 ☐ Yes 2 🛣 No
	28e	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What Cou	intry?
	n with		3349 Midland Ct.				21	.009				Ph	ilippine	
	deat	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13. V			spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Ameri Black, White	
9	or Ite	亞	1 Never Married 2 Married	1 Tes 2 If Yes, Give			Tes, spec			, ruento i	iican, etc.)		· ·	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28e-f show the Medical Examinar must be rictified at	d by	3X Widowed 4 ☐ Divorced	Year or Dates:										ilippino
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au	lid be lental rked o	To B	Joaquin (nmn) Ab	as					Tona	acia	Ocaba	(unl	c)	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or Items 23a or 28e-f show eumatic event, Ite Medical Examinat must be notified at		19a. Informant's Name/Relationship (7			19b. Mailin	g Address	(Street a					or Town, State, Zij	p Code)
	and 2 salth a n 27 ls		Angelica A. Byrd	 Daughte 						t, Ak	oingdor	1, M	d. 21009	
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. PI	ace of Dispos emetery, crem	sition (Nam natory or of	e of her place	e)	D	ate	20c. L	ocation - City or T	own, State
altimore,	Pages ment of I tent: If its jury or o		`4 □Donation 5 □ Other (Specify			rison	Fores	st Ve	et. i 7	7-27-	-04	Owi	ngs Mill:	s, Maryland
Bail	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic. 9068.		21. Signature of Funeral Service Licen	See /					s of Facility		ne.			
	HUZEG		JANA U	/wys									Maryland	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each	line.	i. Do not ente	er the mode	or dying	g, such as o	cardiac oi	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Chron	ue l	Bestru	dive	A	wwe	ys.	Susean	2		> (Oyean
	Examiner		f	Due to (or as	s a consequ	rence or):			6	9				0
		je	Sequentially list conditions, if any, basing to himselfate cause. Enter Underlying Cause (Disease or injury	b. Dua to (or es	s a consequ	ianda offy					•			
	cuted	Examiner	that initiated events	c									274	
760,	sician and burial-transit		resulting in death) Last	Due to (or as	s a consequ	ence of):								
∞	icate b physic s the b	dicai		d										
9 ×	leath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome	a of pregnar	ncv							004 Data at date.	
Box	atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 🗍 Fetal	death 3	Ectopic pre						23d. Date of deliv Month	Day Year
o.	the d by the ached	nysi	1 Yes 2 No 9 Unknown	9☐ Unknown			, , , , , ,							
	n requires that the de been signed by the should be detached	by P	Part II. Other significant conditions of	ontributing to death I	but not resu	lting in the un	nderlying ca	use give	n in Part I.		23e. Did t	obacco	use contribute to t	he cause of death?
ğ	en sig	pe	Coronary Arts	men Des	ease						×	Yes 2	□No 3□Prol	bably 4 ∏Unknown
မင္ပ	law re as be 2 sho	ple	Congestive He	ant Fai	lune						24a. Was		24b. Were auto	opsy findings available empletion of cause of
~	The ate h page	Completed	()								perfo	rmed?	death?	2□ No
/ita	cien: ertific actor,	Be	25. Was case referred to medical examiner?					10.		of Death	(Check only o	one)		
ot	Physical this cal dir	2	1 ☐ Yes 2 No 27. Manper of Death	Hospital: 1 Inpati		ER/Outpatient 28b. Time of			4 🗀 1401		ne 5 ☐ Resi 8d. Describe		6 Other (Specia	(y)
o	ding h. After funei	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year)	Injury	M	3c. Injury Work 1 □ Y	?" ′es 2 □ N		od. Describe	now inju	ry occurred	
Division of Vital Records,	Atten r dea ector by the	fica	3 Suicide 6 Could not be	28e. Place of In	jury - At ho	me, farm, stre	eet, factory,			-			nd Number or Run	al Route Number,
á	s afte	Certification:	4 Homicide determined	building, e	tc. (Specify)					City or To	wn, State	9)	
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying Ph	ysician: To the best	of my know	viedge, death	occurred a	it the tim	e, date and	place, a	nd due to the	cause(s) and manner as s	stated.
	the H in 24 the F iplete	Medicai	one)	and manner s	tated.	OH ANGOLIN				TI OCCUITE	d at the time,			
	To To Con	~	29b. Signature and title of certifier	11/	1	MD -	29c.	License	-	n/			te signed (Month,	
	121		Marche	11- Kroh		1U,F	146/		1150	042	/	U	7,25,	2004
	h'		30. Name and address of person who c					0 T: T: T	D	100			0104	0
	Sta	te	Claudia A. Kroker 31. Date filed (Month, Day, Year)	32. Hegist	rar's Signat	ure ,				102,	Edgew	ood,	MD 2104	U
	Registr		mm 2 7 200	/ \	مصر	5	Spor	K	,					

			Siai	e or Maryland / i	Certificate of	lealth and Menta <i>Death</i>	Reg. Ng.	14 23526
			1. Decedent's Name (First, Middle, Last)	1			of Death	3. Time of Death
	Physic /Medi		Barbara A	lexavolet		Mon	th Day	Year 1730H
	Exami		4a. Facility Name (If not institution, give street ar	d number)	4	4b. City, Town, or Location of	Death 4c. County	of Death
\mathbf{T}'			Genesia Homewood			Baltimore		
	Funeral		5. Social Security Number 6. Sex 1 ☐ M 2 ™	7. Age (In yrs. last bit	Months Days	If Under 24 Hrs. 8. Dete Hours Min. (Mor.	of Birth th, Day, Year)	Birthplace (State or Foreign Country)
	Director		227-)7-0139	57	Yrs.	Sep	23, 1946	VA
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
	faryla r sho	চ						1 √ Yes 2 No
	the N	ect	10e. Street and Number	Balti	more 10f. Zip Code		10a Citizen of M	
	with po o	ă			,		10g. Citizen of V	
	eath	Funeral Director	6000 Bellona Avenue 11. Marital Status 12. Was	Decedent Ever in U,S.	21212	isnanic Origin? (Specify Ves		States e - American Indian,
_	fter d	E	Arme	ed Forces/ Yes 2 No	/	ispanic Origin? (Specify Yes un, Mexican, Puerto Rican, el	c.) Blac	k, White, etc.
20	urs a	ð	_ If Ye	s, Give or Dates:	1 □ Yes 2 □ N/6	Specify:	Specify	
21215-0020	filed within 72 hours after death with the Maryland Hygiene. wher then "naturel", or Items 23a or 28e-f show ent, the Medical Examilier must be notified at	ted	15. Decedent's Education	16e.	Decedent's Usual Occup	ation	16b. Kind of Bu	Black siness/Industry
218	hin 7	Completed	(Specify only highest grede completed in the complete in the c	ge (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of working ()	Own Hor	ne
2	d wil	Ş	12		omemaker			
nd	al Hy foth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, M	fiddle, Maiden Sumam	е)
<u>ya</u>	Ment the Ment arked	၉	Cornelius Miller Alex	ander		Jeannie Hatt	ie Morriso	n
Maryland	12 should be f n and Mental b is marked of raumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b	. Mailing Address (Street	and Number or Rurel Route I	Number, City or Town,	State, Zip Code)
	and ealth n 27 ner tr		Tamara Thomas/Daughte	ne #101, Oxor				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Exartment must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal to	e) Date		City or Town, State		
E	Pag ment ant: I		4 ☐ Donation 5 ☐ Other (Specify)	orv Jul 2004	Baltimo	ore, MD		
Sall	permit. Departr Imports any inj		21. Signature of Funeral Service Licensee	ss of Facility	77+			
ш	205 20		Hall	n and Funeral en Pastures D:		res Lmore, MD		
			23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause	hat caused the death. Do r	not enter the mode of dying	g, such as cardiac or respira		Approximate Intervel Between
\	Physician							Onset and Death
	/Medical Examiner		Immediate Cause (Finel disease or condition	-INOXIC	ENCEL	shalo pa	+ MY	
	Zxammor	7	resulting in death) a.	Due to (or as a		· And		
	ted nsit	Examiner	₽ D	erebro	von cure	CA 17001	71195	
	amecu el-tra	xar	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a	consequence of):	2		
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9	The law requires that the death certificate be executed site hes been signed by the attending physicien and page 2 should be detached for use es the buriel-transit	Physician/Medical	resulting in death) Last	Due to (or as a c	ionisoquenca di).			
Вох	eath cert attendin	1	d	<u>.</u>				
œ.	death e atte	Sicient	Part II. Other significent conditions contributing	to death but not resulting in	the underlying ceuse give	en in Pert I. 23b.	Did tobacco use con	tribute to the ceuse of deeth?
P.0	thet the der	چ	Tichemic	11 -	11 .	416		3 Probably 4 Unknown
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of Vital Records,	w requires thet been signed I should be det					24a.	Was en autopsy performed?	24b. Were autopsy findings available prior to
ပ္ပ	aw n es be 2 sh	Completed			8 W * day 8			completion of cause of deeth?
æ	The law ete hes page 2	ĕ		J.	1□ Yes 2□No	1 ☐ Yes 2 ☐ No		
ita	icien: The certificete rector, pag	Be	25. Was case referred to medical examiner?			26. Place of Death (Check	only one)	
<u></u>	G S Z	2	- Hospital	□ Inpatient 2 □ ER/Out	tpetient 3□ DOA Othe	^{or:} 4□ N ūrsing Home 5□	Residence 6 □Othe	r (Specify)
u	ding Ph h. After th funeral	ä	27. Manner of Death 28a. D	ate of Injury 28b. T Month, Day Year) Ir	ime of 28c. Injury	at 28d. Desc	ribe how injury occurre	od
Si	Attending or death. ector: After by the fune	cati	2 ☐ Accident investigation			res 2 □ No		
Division	il or Attendin after death. I Director: Aft d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At home, far uilding, etc. (Specify)	rm, street, factory, office		ion (Street and Numbe r Town, State)	r or Rural Route Number,
0	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	2						
	Hospital	edical	29a. Certifier Check only 2 Medical Examiner: On the	e basis of examination end	, death occurred at the time d/or investigation, in my op	e, date and place, and due to inion, death occurred at the t	the cause(s) and m <i>a</i> n ime, date and pla <i>c</i> e, ar	ner as steted. nd due to the cause(s)
	To the Within 2 To the comple	Med	one) and r	nanner stated.	29c. License			(Month, Dey, Year)
	8 4 \$ 4			W Ess	0	100/		26 -OL
	X	-						
	* *	`	30. Name end address of person who completed	cause of death (Item 23e)	20 ven B	12, 530180	more, M.	U 51538
	Sta	te.	0.01	2 Registrer's Signature				
	Registra		1111 2 7 2004	heneva	& long			

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04	702		1 For State	State o	f Maryland	_	artment of H		d Mental I		000		Ch 27 27 Ch top
			Registrar 1. Decedent's Name (First, Middle)	n (nat)		Ce	rtificate of	Deam	2. Date of	Reg.	No.	13	23521
	Physici	an							Month		Day 1	Year	3. Time of Death
	/Medic	al	Rachel	Elizabet		Atwo		-11	July	23,	2004		0117 A M
1	Examin	er	4a. Facility Name (If not institutio				4b. City, Town, o		Death		4c. County of	of Death .timo	***
-			Dulancy Valley Roa 5. Social Security Number	6. Sex	7. Age (In yrs. la:	st hirthday)	If Under 1 Year		Hrs. 8 Date of	Rinth			
п	Funeral Director		136-78-3381	1 ☐ M 2 💢 F	20	Yrs.	Months Days		Hrs. 8. Date of (Month) June	Day, Ye	ear)	Cour	place (State or Foreign htry) Jersey
			Usual Residence of Decedent		20				pulle .	20,	1904	IVEW	Jersey
	/land		10a. State 10b. County		10c. City,	Town or Lo	ocation					1	Od. Inside City Limits
	Man	ţō	Maryland Balt	imore	Pi	hoeni	x						1 ☐ Yes 2 🙀 No
	r 288	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of W	hat Cour	ntry?
	3a o	0	7 Fairwood Vie	w Court			211	131			USA		
	deat ms 2	Jer	11. Marital Status		edent Ever in U.S	. 13.	Was Decedent of h	lispanic Origin	? (Specify Yes or	No-	14. Race		an Indian,
9	after or Ita	by Funerai	1 XNever Married 2 ☐ Mar		2 X No		If Yes, specify Cub		uerto Hican, etc.)		c, White,	etc.
8	ral',	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:		1 ☐ Yes 2 🌠 No	Specify:			Specify:	Whit	e
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ant, the Medical Evarifier most be notified at	Completed	15. Deceder	t's Education st grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of	workina	16b	o. Kind of Bus	siness/In	dustry
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Baltimore,	e = t		20a. Method of Disposition 1 Burial 2 X Cremation	3 □Removal from	0.00	netery, cre	natory or other pla	се) 7	/25/04	200	c. Location - 0	or ity or it	own, State
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			23a. Part1. Enter the disease, of heart failure. List	only one cause o	each line.	Do not en	er the mode of dyir	ng, such as car	rdiac or respirator	y arrest,			Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to	(or as a conseque	of):							
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Вох	death certifi e attending I ed for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live b	tcome of pregnand pirth 2 Fetal o	leath 3[Ectopic pregnancy	y			23d. Date Mont		ry Dav Year
0	0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4∐Pregr 9□Unkn	nant at time of dea own	ith 5L	Other (specify) _			-			,
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?						Death (Check or				
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sio	Attanding ir death. ector: After by the fune	cati	2 Accident invest	gation 7 23		1:05		Yes 2 No	-that	105	T CON	1 TW	1
Division	l or Attano after death Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place	of Injury - At homing, etc. (Specify)		eet, factory, office		28f. Location	n (Street Town, S	tand Number tate)	r or Rura	Route Number
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2004 Medical	ig Physician: To the Examiner: On the b	best of my know asis of examination	ledge, deat on and/or in	h occurred at the tir vestigation, in my o	me, date and p pinion, death o	lace, and due to	the cause	e(s) and man and place, ar	ner as st	ated. the cause(s)
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7	i		V410	not	101		0.0	.M.E.		Jl	uly 23	, 20	U 4
	(0		30. Name and address of person	who completed cau	se of death (Item 2			Ctroot	Do1+		Marra	277	21201
	Ψ		5. K. 1	109 AT	Camintag de C'e : :		11 Penn		DGTTTIM	ле,	MALY	aill	CTCOT
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** WILLIAM HOWARD BENSER 10:35 AM JULY 24 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1∰M 2□F 78 Yrs Dèc. Marvland 219-10-1551 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XXIIIo Maryland Harford Joppa Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1001 Pine Road 21085 USA "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner & Operator Restaurant permit. Peges 1 and 2 should be filed of Department of Health and Mental Hygic Important: If Item 27 Is marked other 1 any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be ဂ္ Rose Augustine Combs William (nmn) Benser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1001 Pine Road, Joppa, Maryland 21085 Elizabeth P. Benser / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial - 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
21. Signature of Pure rate species Licensee Highview Memorial Grdns 7-28-04 Fallston, Maryland ^{22. Name and Address of Facility}
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 ODC9 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severa ure (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 99 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Diractor: A investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier death (Item 23a) (Type, Print) 30. Name and address of person who completed cause LAW STREET 8 DR. MANUEL LAZATIN -ABERDEEN, MARYLAND 21001 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 7, 2004 Registrar

			State of Maryland / Depar	tment of Health and Mificate of Death	•	2021 2020
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) Theodore A. BAIRD	4b. City, Town, or Location of Death ${\sf Dundalk}$	2. Date of Death Month JULY	Day Year 3. Time of Death 3. County of Deeth
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Nov. 25	Baltimore 9. Birthplace (State or Foreign Country) 1924 Pa.
	the Maryland r 28a-f show notified at	Director	10a. State Md. 10b. County Baltimore 10c. City, Town or Loca Dund:		10g.	10d. Inside City Limits 1 ☐ Yes 2 🕅 No Citizen of What Country?
30	I within 72 hours after death with the Maryland jiene. I than "naturel", or Items 23e or 28e-f show the Medical Exercises must be notified at	by Funeral D	1 Never Married 2 N Married 1 N Yes 2 No	21222 us Decedent of Hispanic Origin? (Speces, specify Cuban, Mexican, Puerto		JSA 14. Race - American Indian, Black, White, etc. Specify: White
9500-61212	within 72 ene. than na	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. Cost	nt's Usual Occupation of of work done during most of working o NOT use retired) t Analyst For	eman 16b	Kind of Business/Industry Beth. Steel
aryiand	2 should be filed and Mental Hygi Is marked other eumatic event, I	To Be (17. Father's Name (First, Middle, Last) Theodore F. Baird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing		Dolmets Note Number, Cit,	sch
more, ma	Pages 1 and 3 ent of Heelth nt: If item 27 'y or other tr		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition	tory or other place) July	Date 20c.	Id. 21222 Location - City or Town, State Baltimore
Baltimo	permit. Pa Departmen Importent: any injury			merit Funeral		
	ate be executed Medical Examiner The burial-transit	ical Examiner	23a. Part 1. Enter the disease of complications that caused the death. To not enter shock, or heart failure. Let only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the cause of the cause o	the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death On Month
. Box o	the death certific y the attending p iched for use as i	Physician/Med		ctopic pregnancy other (specify)		23d. Date of delivery Month Day Year
cords, P	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		o use contribute to the cause of death?
Ě	The ete ha	e Completed	25. Was case referred to medical	26. Place of Death	24a. Was an autopsy performed? 1 Yes 2	
0	Phy rald	To B	examiner? Hospital:	3□ DOA Other: 4□ Nursing Hon		
DIVIS	To the Hospital or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the funer	il Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or		City or Town, Sta	,
	To the Hos within 24 hr To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invessing and manner stated.	courred at the time, date and place, a stigation, in my opinion, death occurre	ed at the time, date a	(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) Type, Print 1976	100047157 "itt Blvd.Su	ite 14	1.27.2004 Balto mb.
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year)			

ORIGINAL

			State of Maryland / Department of Health a 1 - State State Certificate of Death		2001 22500
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	
	Physici /Medic	_	VV / / / / 9/8 // 3 // / / / / / / / / / / / / / / /	July :	22 2004 7-30 PM
>	Examin		An Charles Name (March treet at a street and avertee)	of Death Raltimore	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 230 - 34 - 24 - 250 12 M 2 F 73 Yrs.	* 7 7	9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	OEF7. V	
	Manyia I-f shov	tor		TORE CI	10d. fnside City Limits Yes 2□No
	vith the	Director	10e. Street and Number 10f. Zip Code		g. Oltizen of What Country?
	ns 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or	gin? (Specify Yes or No-	14. Race - American Indian,
36	hours after death with the Maryland turel', or Items 23e or 28e-f show at Examinar must be notified at	by Fur			Black, White, etc. Specify: 01 20 2
9-0	"neturel",	ted b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	1	6b. Kind of Business/Industry
21215-0036	be filed within 72 ha ital Hygiene. id other than "netu evant, II.e Madical	Completed	(Specify only highest grade completed) [Give kind of work done during mos life. DO NOT use retired) [Hendentary/Secondary (0-12) [College (1-4or 5+)	-	BARBERSHOP
	e filed v I Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	er's Name (First, Middle, M	0/1/00 / 0
Maryland		To B	ERNEST DROWN ELI	ZABETH	HARMON
Mar	an a		19a. Informant's Name/Relationship (Type, Print) ARLEAVER BELL (NIECE) 19b. Mailing Address (Street and Number 19b) 19c. Informant's Name/Relationship (Type, Print)		
Je,	ges 1 and 2 t of Health if item 27 or other tr		20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	c. Location - City or Town, State
Baltimore,	Pages tment of l tant: If it		'4 Donation 5 Other (Specify) MT, ZION CEMETERY, C		ANSOCUNE MARYLAND
Ba	permit. Pag Department Important: I any injury o		21. Signature of Fun-ral Service Licensee	TON AVE.	BALTO MP. 21217
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one on each line.		st, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		240
8	Examiner		Sequentially list conditions, b. Sequentially list conditions,		
-	ed	niner	if any, leading to immediate Due to (or as a consequence of):		
· ·	execul an and rial-trar	Examin			
928	cate be executed physician and the burial-transit	dical	a Dehydration		
Box 6	eath certific attending p I for use as	ın/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetaf death 3 □ Ectopic pregnancy		23d. Date of delivery
O. B	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Unknown		Month Day Year
Δ.	res that i	by Ph		. 23e. Did toba	acco use contribute to the cause of death?
ord	w require been si should t	eted	Klool Tallare	-	s 2 No 3 Probably 4 Unknown
Records,	The taw ate has b page 2 s	Completed		24a. Was an autopsy perform	ed? prior to completion of cause of death?
Vital		Be Co	25. Was case referred to medical 26. Place	1 ☐ Yes 2 of Death (Check only one	No 1 □ Yes 2.40 No
of V	Phys this al di	은	1 ☐ Yes 2 M No Hospital: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nu	rsing Home 5 Resider	
ion	nding th. r: After e funer	ation	1 I Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation Natural S ☐ Pending Pending		williary occurred
Division	or Atter frer dez Sirector in by the	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town,	eet and Number or Rural Route Number, State)
	spitel			d place, and due to the car	use(s) and manner as stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea and manner stated.	th occurred at the time, da	te and place, and due to the cause(s)
	_	-	29b. Signature and title of certifier 29c. License number D 155	03 29	d. Date signed (Month, Day, Year) TUI, 23 2004
7	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	act Balti	1/10 2/17
	- 64		31. Date filed (Marth. Bay Year) 1001 31. Date filed (Marth. Bay Year) 1001 31. Registrat's Signatures	124111	ron IVII) xlalt
	Sta Registi		JUL 2 7 2004 Sparks		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of N	Marylan						lental Hy		000	1.	22521
				ast)		00,	incate	OIL	Jeani		2. Date of D	No. 24	. U U	1-3	3. Time of Death
	Physici		Edward Jol	n Bryan	t.						Month		200	Year)4	8:00 A ^M
	Examir		4a. Facility Name (If not institution, gi	ve street and numbe		-				of Death	oury				, 0.00 11
		Design Name First Moral Last Last													
	Funeral Director		5. Social Security Number 6. 050-12-8228	Certificate of Death Rose, No. 2 1 2 3 5 7 7 8 8 1 7 1 8 1 7 8 9 2004 2 3 5 7 8 1 8 1 100 5 8 1		place (State or Foreign									
			Usual Residence of Decedent												
	death with the Maryland ms 23a or 28a-f show	J.	,		10c. City									1	0d. Inside City Limits 1 ☐ Yes 2 1 No
	the M	ecto				В						10- 00			
	with			Road			TOT. ZIP)15			Tog. Citi			itry?
	death	era		12. Was Deceder		S. 13.	Was Deced			gin? (Spe	ecify Yes or N	0-			an Indian,
9	ours after death with the Maryla 'al', or Items 23a or 28a-1 shov Examment must be invitted at		1 ☐ Never Married 2 Married	1 X Yes 2 F	7 No)					Rican, etc.)		Black		
003	"natural", or Ite				:1938-	44									
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ylaı			George Blodzin	ski					Ro	se D	rozdal				
Maryland 21215-0036	s 1 and 2 should f Health and Men itam 27 Is marks other traumatic														Code)
	1 and Health am 27			/Daughter	20b. Pl				Lane						State
nor	ages ant of t: If it y or o		1 ☐ Burial 2 X Cremation 3	Removal from Stat	_ C6	emetery, crer	natory`or ot	her place				1		-	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 It any injury or other tra once.		21. Signature of Funeral Service-Lice	nsee 4 · 4	1100	22	. Name and	d Address	s of Facilit	у			LLIMO	,,,	LID
ä	permit. Depart Import any inj		2000001- 7.	/	-	Cı	emati	on S	Socie	tv o	f MD, 1 Baltim	Inc.	MD 2	1228	}
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plications that cause one cause on each	ed the death line.										Approximate Interval Between
- 2	Physician		disease or condition	LU	NC	CA	NC	EY	5						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	is a consequ	ience of):									
		-0	Sequentially list conditions, if any leading to immediate	b. Due to (or a	is a consequ	ence of):								-	
	uted d ansit	min	cause. Enter Underlying Cause (Disease or injury	·	· ·	,									
0,	an an	Еха	resulting in death) Last	Due to (or a	s a consequ	ience of):									
8760,	death certificate be executed e attending physician and ind for use as the burial-transit	lical		_ d.											
9	ding p	/Mec		22a If you outcom	o of progner										
Вох	attend for us	clan	in the past 12 months?	1 Live birth	2 🗌 Fetal	death 3						2			•
o.	the d by the ached	ysi			a 51 00	au	Other (spe	y)							
ري. ص	requires that the de een signed by the a hould be detached f		Part II. Other significant conditions	contributing to death	but not resu	lting in the ur	nderlying ca	use give	n in Part I.		23e. Did 1	tobacco u	se contrib	ute to th	e cause of death?
ord	w require been sig should b	ted t	Chronic obstr	uctive	Puli	mona	ry	dis	eas	<u>e</u> _	1 🗆	Yes 2	□No 3	Proba	ably 4 DUnknown
Records,	> D 10	ple	ATRIAL F	BRILL	ATIO	<u>م</u>	· · · · · · · · · · · · · · · · · · ·						24b. We	ere autop	ssy findings available
<u>~</u>	G 17	Con									perfo	ormed?	[dea	ath?	
Vital	Physician: Th this certificate ral director, pag	Be	examiner?	Hospital				Otho							
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ion	Attending r death. ector: After by the funer	ation			lay Year)								, 50001100		
Division of	er des rector	tifica	3 ☐ Suicide 6 ☐ Could not I	286. Place of II	njury - At hor	me, farm, str	eet, factory,	office		- 2	28f. Location (Street and	d Number	or Rural	Route Number,
D	ital or irs after ral Dli led in	Cer		- Dunding, t	oto: (opoony,						0.0, 0.70	State)			
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funeral Director: After th completely filled in by the funeral	dical	(Check only 2 Medical Exa	miner: On the basis	of examinati	vledge, death ion and/or inv	occurred a restigation, i	t the time in my opi	e, date and nion, deat	d place, a h occurre	and due to the ed at the time,	cause(s) and	and manr place, an	ner as sta d due to	ated. the cause(s)
	Fo the	Me	29b. Signature and title of certifier	1			29c.	License	number			29d. Date	e signed (Month, E	Day, Year)
	1/1		> Kl	\supset \angle	20		P	55	-14	3		7	1/2	61	04
	1011		30. Name and address of person who			23a) (Type,	Print)			D I	1 -	. \		- 1	-
	1		KARL SPECTOR	2, MD	201		LCAT	ER	2	pse l	HIV Y	ND	210	15	
Ŀ	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 7 200		trar's Signat	G	Span	Ks/							

For

				Registrar			Cen	iticate of	Death		Reg. No.	nn.	22522)
			ų.	1. Decedent's Name (First, Middle, La						2. Date of D	eath .— Day	Year	3. Time of Death_	,
		Physicia /Medic		Edward Behrma	n					JUL'	7 2		10540A	Λ
		Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of De	ath	4c. (County of Dea	th	
				ST AGNES H	EALTHCA	HRJ=		BALT	IMUR	E		N/A		
		Funeral		5. Social Security Number 6. S		e (In yrs. las	st birthday)_	If Under 1 Year Months Days	If Under 24 H		irth	9. Bir	thplace (State or Foreig	'n
		Director		150-24-4838	□M 2□F	71	Yrs.	MOILINS Days	HOUIS M	Oct 9,			York	
		ס		Usual Residence of Decedent			•			001 9,	1932			_
		ylan		10a. State 10b. County			Town or Loca						10d. Inside City Limits	
		Mar Fed	to	Maryland Baltimo	re	Cato	nsvill	.e					1 ☐ Yes 2.X No	٥
		r 28g	irec	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What C	ountry?	
		death with the Maryland sma 23a or 28a-f show ir reast be notified at	Funeral Director	711 Academy R	oad			21	.228			USA		
		na 2	ere	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13. W	as Decedent of H	lispanic Origin?	(Specify Yes or Nerto Rican, etc.)	10- 1	4. Race - Ame		
	(0	rite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💽			Tes, specπy Cuba ⊒Yes 2⊠No		erto nican, etc.)		Black, Whi	te, etc.	
	8	urs a	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		110	⊥ tes 2LZLNo	Specify:			Specify: W	hite	
	Maryland 21215-0036	2 ho natur	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Decede	nt's Usual Occup	ation	vorking.	16b. Kin	d of Business	/Industry	
	7	hin 7	ple	Elementary/Secondary (0-12)		5+)		rid of work done O NOT use retired	d)	vorking				
	7	d wit	оп		College (1-4or 5 5+		Phys	sician			He	althc	are	
	ਲੂ	othe othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middl	e, <i>Maid</i> en S	Sumame)		
	<u>a</u>	lid by lenta rked rked	ToE	UNK					Anne	ette		UN	IK	
	ary	should had a		19a. Informant's Name/Relationship (* .		19b. Mailing	Address (Street	an <i>d Number</i> or	Rural Route Num	ber, City or	Town, State,	Zip Code)	
	Ž	nd 2 alth a 27 is r tra	5	Robyn B. Lupo/	Daughter		7315 N	Varrow W	ind Way	Columbia	a, MD	21046		
	ē,	Hear Hear Hear Hear Hear Hear Hear Hear	II i	20a. Method of Disposition		20b. Pla	ce of Disposi	tion (Name of atory or other place	cel	Date	20c. Loc	ation - City or	Town, State	
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event. The Medical Evantrior reast be truffled at once.		1 Burial 2X Cremation 3 C 4 Donation 5 Other (Specia				natory,	\tilde{I} nc. 7	/22/04	Balt	timore,	MD	
	≢	artme ortan injur	11 3	21 Signature of Funeral Service Lice	ISBB //				1					-
	Ba	Departing Department of the post of the po		Polywood A. In	ww	1.	Cı	cematio	n Soci	ety of	MD,	Inc.	MD 04000	
		*		23a Part Enter the disease or com	regorchi	the death	Do not enter	the mode of dvir	Lerick	Road Ba	ALTIN arrest	iore,	MD 21228 Approximate	
_	г			23a. Part1. Enter the disease, or com shock, or heart failure. List only					.9,	,			Interval Between Onset and Death	
		Physician		Immediate Cause (Final disease or condition resulting in death)	aP/	VEUN	MONI	A					~ 6 day	2
		/Medical Examiner		resulting in deality	Due to (or as	a conseque	ence of):						,	
	8	Examinor	_	Sequentially list conditions,	b									
K	4	pg tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	mice of).							
4		ecute and tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	2 2020200	ann of							
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	68760	ate b hysic the b	n/Medical		_ d.							-		
1-1		e as	Me	IF FEMALE:	00 1/									
Q	30X	ith ce		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal c	death 3□E	Ectopic pregnancy	у		2	3d. Date of de Month	livery Day Year	
A). B	e dea	Sic	1 ☐ Yes 2 ☐ No	4∐Pregnant a 9∐Unknown	t time of dea	ath 5	Other (specify)					,	
>	P.O.	sician; The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physicla	9 Unknown						00. 511	l Anhania		Ab	
7	s,	gnec be de	by	Part II. Other significant conditions				derlying cause giv	ven in Part I.				the cause of death?	
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111	ecords,	aw re	plet	DIABETE	S MEL	-1-1	TUS	•		24a. Wa	s an opsy	24b. Were a	utopsy findings available completion of cause of	Θ
7 1	α	The tre ha	Completed	HYPEPT	ENSI	ON				per	formed?	death?		
2	Division of Vital	an: tiffica tor, p	Be C	25. Was case referred to medical	L 1421	<u> </u>			26. Place of E	Death (Check only				
A	>	Physician: this certific ral director,	To B	examiner? 1 Tes 2 No	Hospital:	ent 2 E	R/Outpatient	3□ DOA Oth	ner: 4 🗆 Nursin	g Home 5 ☐ Res	sidence 6	☐Other (Spe	ecify)	
\sum	o	Physical of the strain of the		27. Manner of Death	28a. Date of Inju	-	28b. Time of	28c. Injui Woi		28d. Describe			,,	П
\propto	o	Attending r death. sctor: After by the funer	ţ	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation		iy rear)	Injury		rkr Yes 2∐No					
7	S	Attendideath ctor: A y the fo	fica	3 Suicide 6 Could not t	e Con Dines of In	jury - At hom	ne, farm, stre	et, factory, office	-	28f. Location	(Street and	Number or R	ural Route Number,	
EHRMAN	$\frac{1}{2}$	ppital or Attanding Physours after death. Interpretation: After this filled in by the funeral di	Certification:	4 Homicide	building, et	tc. (Specify)				City or I	own, State)			1
SE		spita tours neraj	alc		nysician: To the best									
سلابا		To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exa	miner: On the basis of and manner st		on and/or inve	estigation, in my o	opinion, death or	courred at the time	a, date and	place, and du	e to the cause(s)	
		To th Withir To th comp	M	29b. Signature and title of certifier	2			29c. Licens	se number				th, Day, Year)	
		d		1	ΛD			PI	6+0)5	JU	LY 2	.2 2001	4
		J		30. Name and address of person who	completed cause of	death (Item :	23а) (Туре, Р	rint) A A I	m n 11	EALT)-	1 1 1	-	-	1
				KRISTINE	DEIILO	rt	21	AGNI	es H	EALL	tCH	KL		11
		Sta	atė	31. Date filed (Month, Day, Year)		rar's Signatu	ire &	don V	11					
		Regist	rar	JUL 2 7 20	104 Arm	war	~	popula						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SALONIS ORCIVE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Roles medical un MUNDA 8. Date of Birth (Month, Day, Year) April 29,1924 Inder 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗗 F Hours 80 219 16 5913 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
shir: If item 27 Is marked other than "naturel", or Items 23a or 28a-f show ans. If item or 18 marked other than "naturel", or intermist be multiful at any or other treumatic event, its Mactical Examination and be multiful at 1 Yes 2 □ No Maryland N/A Baltimore Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21225 U.S. 604 Washburn Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status e filed within 72 hours after di Il Hygiene. other than "neturel", or Item 1 ☐ Yes 2 ∑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No δ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Elementary School 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maggie Krlywicz Joseph Frank Gabor 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / son Alan Balonis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Department o Importent: If any injury or once. 7/26/2004 Holy Cross Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 omerouse 23a. Part1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Neurona **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s After this certificate has autopsy performed? 20 1 ☐ Yes Be director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel C 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only and manner stated 29b. Signature and title occertif 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 7 2004 Registrar

				partment of Health and Mertificate of Death		ene	23531.
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal		yd, Jr.	7 24	2004	3:р м
1	Examir	er	4a. Facility Name (If not institution, give street and number) Sandtown Winchester	4b. City, Town, or Location of Death		4c. County of Death	
Н	Funeral			Baltimore H Under 1 Year H Under 24 Hrs.	8. Date of Birth	NA 9 Righ	place (State or Foreign
	Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 70 Yrs.	Months Days Hours Min.	(Month, Day,) 7-22-34	(ear) Cou	place (State or Foreign stry) S.C.
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or				
	anyla shov	7		imore			10d. Inside City Limits 1 X Yes 2 □ No
	the N	ecto	10e. Street and Number	10f. Zip Code	140		
	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-1 show the Medical Examinar: ust be notified at	Funeral Director	119 McPhail St.	21223	100	 Citizen of What Cou USA 	ntry?
	death ms 2	nera		B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	can Indian,
9	after or its	F	1 Never Married 2 Married 1 Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, White,	etc. lack
8	hours ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: B	1ack
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212	withi iene. r than	Completed		older	F	lynn Fmeri	ch
b	be filed stal Hygie of other avent, II	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
ylaı	should b and Ments s marked umatic a	To	Robert Whittier	Agnes		Boyd	
Maryland 21215-0036	12 short h and 7 is m			iling Address (Street and Number or Rural McPhail St., Balti			Code)
	is 1 and 2. If Health ai itam 27 is othar treu				-	c. Location - City or To	Ctata
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other treumatic avent, the Medical Exaction or usit to notified at once.		14 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	rematory or other place)		Lansdowne,	
aĦ	permit. I Departm Importer any injui			22. Name and Address of Facility	Balt	imore, Md.	21202
<u> </u>	Ped E ma		Kabrulle Cisk	March F.H. East		. North Ave	
7	/Medical Examiner	Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any least of timmediat cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	nter the mode of dying, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	by Physician/Medical E	d	□Ectopic pregnancy □ Other (specify)		23d. Date of delive	rry Day Year
	w requires that been signed should be de		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	
Records,	The law re ate has ber page 2 sho	Completed			24a. Was an autopsy performed	prior to cor death?	osy findings available inpletion of cause of
Vital	cian: ertific ector,	Be (25. Was case referred to medical examiner?	26. Place of Death		110	22.110
ō	Attanding Physician: The le r death. ector: After this certificate has by the funeral director, page 2	atlon: To	1 Yes 2 No		ne 5 Residence 8d. Describe how i	e 6 □Other (Specify injury occurred	
Division	tal or Att rs after de el Directi ed in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 2	8f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	To the Hospital or Attandi within 24 hours after death. To the Funarel Director: A completely filled in by the to	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, dea Medicel Exeminer: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place, as nvestigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To To Com	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L	Day, Year)
	0		I produce	n 1)2976	4	1/26/01	1
	8		30. Name and address of person who completed cause of death (Item 23a) (Type Why ca was De Albu eva L 31. Data like (Mostly Was L)	(Print) 5/6 N. R.	lan As	P Bult	12228
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Spark	J		

			1 - For State Registrar	State of Maryla		artment rtificate			and M		iene	004	23535
I	Physic /Medi		Decedent's Name (First, Middle, Last) Lottie	L.		Breed	den			2. Date of Dea	th Day	Year 200	3. Time of Death
	Exami		4a. Facility Name (If not institution, give tunion Mem. Hosp.	street and number)			Town, or Ltime	Location o	f Death	2019		ounty of Dea	
	Funeral Director		5. Social Security Number 6. Security Number 212–18–4823	7. Age (In yr. 84	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 2-4-	Year) 20	9. Bir	thplace (State or Foreign ountry) Md.
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation							10d. Inside City Limits
	Be-f st	ctor	Md. NA		Balt	imore							X□Yes 2□No
	23a or 2	al Dire	3921 Monterey Rd.			10f. Zip 2]	Code L218			1	0g. Citize	n of What Co	ountry?
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-1 show or other traumatic event, the Modical Examinat cust by intified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 Yes 2		spanic Origin, Mexican Specify:	gin? (Spe , Puerto f	city Yes or No- Rican, etc.)		. Race - Ame Black, Whit pecify: B	
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nd	12 should be filed within h and Mental Hygiene. 7 is marked other then "traumetic event, the Moo	Be C	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle, I			
Maryland	hould to markace	2	George 19a. Informant's Name/Relationship (Ty)	H.	Pari		(2)		net			inson	
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rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying ca	use giver	n in Part I.			acco use		the cause of death?
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			Danielle F. G	randrimo,	M.D.	A	Ta	438	946	-C3	JUL	1 22	, 2004
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	/Medic Examir		4a. Facilit		not institution	, give s	treet and nu	mber)/		46.0	ity, Town, o	or Location of De	ath	40	. County		
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Division	or Att	Certification		Suicide Homicide	6 □ Could n determi		28e. Płace buildi	of Injury - A	t home, farm	street, fact	ory, office		28f. Location City or 7	(Street an	d Number	or Rural	Route Number,
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	To tha Hospital or Attanding I within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	edical		ck only	Certifying Medical E	g Physi Examin	er: On the b	asis of exam	knowledge, d ination and/o	eath occurre r investigati	ed at the time	ne, date and place pinion, death occ	ce, and due to the	e cause(s) e, date and	and man	ner as stand	ted. he cause(s)
	To tha within 2 To the complet	Med	29h Sign	,	itle of certifier		and man	ner stated.			9c. License						
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	10		JU. Name	and addres	ss of person v	vno opn 7 – 1		e of death (I	_	la 9	5 h	Imer	nie A	211	53 4		
	Sta	te	31. Date 1	iled (Month	Day, Year)			egistrar's Sig		1		111000					
	Registr			JUL	272	304	Pi	account the same	Ø	100	rele						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 23 Darrel1 Robert Buckley Julv2004 2:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Richie Hospice House Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Day, Year) May 11, 1942 Birthplace (State or Foreign Country)
 IA **Funeral** Days Months Hours 1**⊠**M 2□F Min. 62 Director Yrs 482-46-9117 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. Its Mudical Experimentation recities at 1 ☐ Yes 2 No Director MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7511 Saffron Court 21076 U.S.A. death v by Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 K Yes 2 □ No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. fited within 72 hours after 1 Never Married 2 M Married Baltimore. Marvland 21215-0036 1 ☐ Yes 2X No Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1.2 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Warrant Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Buckley Olive Vivian Olsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau Mrs. Sandra Buckley / wife 7511 Saffron Court, Hanover, MD 21076 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation | Jul 28,2004 Stevensville, MD 21. Signature of Jun al Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that ceused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician di disease or condition resulting in death) /Medical Due to (or as a con: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 DUnknown Completed 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Spec 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Latural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director; 6 ☐ Could not determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day Year)

Registrar

State

31. Date filed (Month, Day, Year)

JUL 2 7 2004

mpleted cause of death (Item 23a) (Type, Print)

2. Registrar's Signal

		State of Maryland Department of Health and Mental Hygier State of Per FH, G835, 09/09/04dhb Registrar	ne N2 N N L 2 2 2 2 0
Physicia		Decedent's Name (First, Middle, Last) Death	Day Year 14:20 M
/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death Baltimure City
Funeral Director		5. Social Security Number 6. Sex 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Days Hours Min. 1/29/	9. Bitthglace/State or Foreign
D.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
h the Mar r 28a-f sl	Director	MD Baltimore City Baltimore 100. Street and Number 100.	1 Ves 2 □ No Citizen of What Country?
death wit	neral D	16 Aisquith St. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
0036 ours after rai', or ite	by Funeral	1 Never Married 2 Married 1 1 Yes 2 No If Yes, Give Year or Dates:	Specify:
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Sedintary (0-12) April 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Description) If a. Decedent's Usual Occupation (Give kind of work done during most of working life. Description) If a. Decedent's Usual Occupation (Give kind of work done during most of working life. Description)	Kind of Business/Industry NOTE C
uld be file Mental Hy irked oth titc event	To Be (17. Father's Name (First, Middle Dest) Lec Sic. 18. Mother's Name (First, Middle Dest) Minnie Penr	
and 2 sho ealth and N n 27 Is me		19a. Informant's Name/Repartionship (Type, Print) EANE SUCCE 19b. Mailing Addges (Streft and Aumber on Retral Route Alymber, Cit. X	PATA, State (Alo Gode) DUD
mit. Pages 1 and 2 partment of Health portant: If item 27 I y injury or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Action - City or Town, State
Dallimor permit. Pages Department of th Important: if ite any injury or of		21. Signature of Funeral Service (Cense) 22. Name and Address of Facility (1560 H C) 23. Dame and Address of Facility (1560 H C) 24. Name and Address of Facility (1560 H C)	KUB SUJ. HOME PATU, NG. DIZA
Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death) a. Due to (or as a conjequence of):	
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated svents c.	
cate be executed physician and the burial-transit	dical Exa	resulting in death) Last Due to (or as a consequence of): d.	
DOX OF DOX OF THE OF TH	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23c. If yes, outcome of pregnancy 1 Clive birth 2 Fetal death 5 Other (specify)	23d. Date of delivery Month Day Year
quires that the signed by	by		co use contribute to the cause of death? 2 \(\sum \) No \(3 \sum \) Probably \(4 \sum \) nknown
Or vital nector as, Physician: The law requires the this certificate has been signed rail director, page 2 should be con	Completed	Recent Preumococcal Preumonia 24a, Was an autopsy performed	
ding Physician: The After this certificate funeral director, pag	ion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	
OIVISION I or Attending after death. Director: Attention by the fune	ertiflcation;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
UNISING To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (Check only one)	v(s) and manner as stated. and place, and due to the cause(s)
To the within To the comple	Med	29b. Signature and the of configure 29d. License number 29d. I	Date signed (Month, Day, Year)
		1993 ES-000	7/22/04
V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN T- SCHOWINSKY, MD GOONGRITH GOICE SF. BOST BOOKS 31. Date filed (Month, Day, Year) 132. Registrar's Signature 133. Registrar's Signature 134. Registrar's Signature 135. Registrar's Signature	Himore md 2057
Sta Registr		31. Date filed (Month, Day, Year) 132. Registrar's Signatury Spaces	

			1 - State Registrar AMEND ITEM #	State of Ma 22 PER FI	aryland II G83 :	1 / Depa 7/2	rtment (V) tilicate	of H	ealth a D <i>eath</i>	and Me		iene	04	23539
			1. Decedent's Name (First, Middle, Last)	1						2	. Date of Deat		=	3. Time of Death
	Physici /Medi		JEROME					BL	UE		Month	Day -	2004	14:03 PM
	Examir		4a. Fecility Name (If not institution, give	street and number)	11	1/1	4b. City	Fown, or	Location of	f Death	7.		y of Deeth	
			Itte John Me	2/1/105	105/	112/	D1.	1/1/	mak		14		N/A	
	Funeral Director		22. (6 133)	7. Age	e (In ya s . Ia 44	st birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min. 8	Date of Birth (Month, Day, 4-10-1	960	9. Birth	plece (State or Foreign ntry) (LAND
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation				-			10d. Inside City Limits
	d within 72 hours after death with the Maryland jiene, rthan "natural", or items 23s or 28s-f show It e Medical Examiner must be motified at	ŏ	MD. N/A			ALTIMO								1√2 Yes 2 □ No
	7.28a	Director	10e. Street and Number				10f. Zip (Code			16	g. Citizen of	What Cou	71
	38 o		2944 GARRISON BL	VD. APT 2	2B			2121	.6			US		•
	items 2	Funerai	11. Marital Status	12. Was Decedent 6 Armed Forces?	Ever in U.S	i. 13. \	Vas Decede í Yes, specif	ant of Hi	spanic Orig	in? (Specif	fy Yes or No-	14. Rac	ce - Ameri	can Indian,
9	or its	Y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ N If Yes, Give X	10	1	Yes 2	•		, FUBITO MI	can, etc.)		ck, White,	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:								Specif	DL	
21215-0036	c 1 3	Completed	15. Decedent's Educ (Specify only highest grade			(Give	lent's Usual kind of work DO NOT use	k done d	luring most	of working	1	6b. Kind of B	lusiness/In	dustry
12	itled within Hygiene. Ither than " ont, it a Mes	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)		LABOR					CONS	TRUCT	TON
	T the T	BeC	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (F	First, Middle, M			
/lar	0 2 0	To E	JEROME BLUE SR.						FLC	RENCE	E TIBBS			
Maryland	2 00 m		19a. Informant's Name/Relationship (Type			19b. Mailin	g Address ((Street a	nd Number	r or Rural F	Route Number,	City or Town,	State, Zip	Code) 21216
	Health Health em 27 I		DOREEN BLUE (WIFE)	1	294	4 GARI	RISO	N BLV			ALTIMO	RE, M	ARYLAND
altimore,	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Pla	nce of Dispo- metery, cren	sition (Name natory or oth	e of her place	9)	Date	θ 2	0c. Location -	- City or To	own, State
Ħ,	permit. Pag Department Important: I eny injury o		'4 □ Donation 5 □ Other (Specify)	. ,	METR	O CRE	MATORY	Y	7	-27-2	2004 E	ALTIMO	RE.	ARYLAND
Bal	permit. Pag Department Important: I eny injury o		21. Signature of uneral Service Linense	ONATHAN	D. H	IIBNER	REDD	FUNE	RAL	SIRVIO	IPS FU	VERAL 1	HOME,	P.A.
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	幾点		shock, or heart failure. List only on Immediate Cause (Final	ie cause on each iin	ie.						espiratory arre	51,		Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	Due to (or as a	Vega	tive	Red	Se	psis					24 hours
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90	cate be executed bhysician and the burial-transit		resulting in death) Last	Due to (or as a	a conseque	ence of):								
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о. О.	ed by the detached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				//						
ω, σ	signed b	by Pi	Part II. Other significant conditions con	tributing to death bu	it not result	ting in the un	derlying cau	use givei	n in Part I.		23e. Did toba	cco use cont	ribute to th	e cause of death?
d	been sig	ed t	AIDS								1 ☐ Yes	2 🗆 No	3 ☐ Prob	ably 4 Dunknown
Vital Records,	as been 2 should	Completed									24a. Was an	24b. \	Were auto	psy findings available
Œ,	p _ q	mo;									autopsy perform 1 Yes 2	ed?/ c	orior to cor death? I □ Yes	npletion of cause of
ita	is certificate director, pag	Be (25. Was case referred to medical examiner?						26. Place o	of Death C	heck only one			20,10
	this certific	2	1 ☐ Yes 2 ☐ No	ospital: 1 Ampatier		R/Outpatient			4 🗀 14012	sing Home	5 🗌 Residen	ce 6 🗆 Oth	er (Specify)
o u	. After t	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury		c. Injury Work			. Describe how	injury occurr	red	
vision	death.	icat	2 Accident investigation 3 Suicide 6 Could not be	One Pleas of Isin			M		es 2 N		1 101			_
	after Direction by	Certification;	4 Homicide determined	28e. Place of Inju building, etc.	(Specify)	ie, iarm, stre	et, factory, o	office		281.	City or Town,	et and Numbi State)	er or Rura.	l Route Number,
	in the mospinal or arterining within 24 hours after death. To the Europeal Director after completely filled in by the funer.	edicai C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner stat	examinatio	edge, death on and/or inv	occurred at estigation, in	t the time n my opi	e, date and inion, death	place, and occurred	due to the cau at the time, dat	se(s) and ma e and place, a	inner as stand due to	ated. the cause(s)
	within 2. To the complet	Me	29b. Signature and title of certifier					License				I. Date signed	i (Month, L	Day, Year)
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6)		30. Name and address of person who cou				Print) DC	CTO	000 2'5 La	UNGE	JU STREET	BALTIN	MORE,	mp
0			ADLAH SUKKARZ, JOHNS				110, 600	00 N	0127Hi	WOLFT:	STREET	2128	7	
¥1	Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	r's Signatu.	B.	Spark	6						

			1 - For State Registrar	State of	Marylan		artment o		alth and N eath		Reg. No.	000	L	2351.0
	Physici		Decedent's Name (First, Middle, La. NAOMI ELIZABETH							2. Date of De	ath Day うし	25	274	3. Time of Death 00; 39 AM
	/Medic Examir		4a. Fecility Name (If not institution, give		ber)		4b. City, Tow	vn, or Lo	ocation of Death		4c.	County of I	11	
			SAINT AGNES HE			1 - 1 - 1 - 1	BAT I	m	OFE If Under 24 Hrs.	O Data of Bird		N/		(8244 5-44
	Funeral Director		5. Social Security Number 6. S 212–34–4369	ex □M 2](0 F	7. Age (In yrs. 6.				Hours Min.	8. Date of Bird (Month, Da 2-1-1		9.		ice (State or Foreign y) YLAND
			Usual Residence of Decedent 10a. State 10b. County			y. Town or Lo	eation						10	d. Inside City Limits
	death with the Maryland ims 23s or 28s-f show intrust be notified at	ō	MD. N/A			BALTIM								1 X Yes 2 No
	or 28a	Funeral Director	10e. Street and Number				10f. Zip Co	de			10g. Cit	izen of Wha	t Count	y?
	23a c	aiD	14 S. BERNICE A					229			-	JSA		
	er des Items	nuel	11. Marital Status	12. Was Deced	ces?	.S. 13.	Was Decedent If Yes, specify	ol Hisp Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - A Black, \	America White, e	
350		þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Give Year or Da	2 LXN0 e ites:		1☐Yes 2【X	(No	Specify:			Specify:	BLA	CK
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151	d within piene. r than	mpi	Elementary/Secondary (0-12) -12-	College (1-	4or 5+)		hleboto				1	Labora	tor	v
2	be filed with stal Hygiene. od other the	Be Co	17. Father's Name (First, Middle, Last						8. Mother's Nam	e (First, Middle,				J
-	2 should be and Mental is marked of aurmatic even	To B	WADE H. MEARS							L. BARN				
20	12 sho h and 7 is mu		19a. Informant's Name/Relationship (GREGORY LANE (SO				-		d Number or Rui E LANE (-			
9	1 and Health tem 27		20a. Method of Disposition			Place of Dispo	osition (Name o	of.	-	Date		ocation - Cit		
<u> </u>	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		state	-	-			-30-2004	OW:	INGS N	ILL	S, MARYLAN
Baltimore Manyland	permit. Pages 1 and 2 should be f permit. Pages 1 and 2 should be f Department of Health and Menial I Important; if Item 27 is marked of any injury of other traumatic eve once.		21. Signature of Timeral Service Libe	ONATH	IAN D.									P.A. AND 21217
032	Physician /Medical Examiner physician and p	ical Examiner	23a. Part Anter the disease, or come shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	ach line.	HU IN quence of):	JAAR CA			or respiratory a	rrest,			Approximate Interval Between Oasek and Death
11	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	aldeath 3	⊒Ectopic pregr ⊒ Other (specif					23d. Date o Month		y Day Year
NAOM NACM	Physician: The law requires that the dribs certificate has been signed by the rail director, page 2 should be detached	Completed by Pt	Part II. Other significant conditions CARDIAC DISE	contributing to de	eath but not res	sulting in the t	underlying caus	e given	in Part I.	23e. Did t		\/	ite to the □ Proba	e cause of death?
之	law requir	ojete								24a. Was		24b. Wei	re autop	sy findings available pletion of cause of
10	VICAL TO INCIDENT THE LANGUAGE THE LANGUAGE HAS RECTOR, PAGE 2	E								perfo	ormed?	dea	th?	No
AKE,	ding Physician: The h. After this certificate h. funeral director, page	Be	25. Was case referred to medical examiner?		,				26. Place of Dea	th (Check only o	one)			
4:	Physic this c	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1		ER/Outpatie		Other	4 🔲 Nursing 🗅	ome 5 Resi 28d. Describe			(Specify)	
D:	Jing Jing After	tion	1 Natural 5 Pending 2 Accident investigation	(Mont	h, Day Year)	Injury	м	Injury a Work?	es 2 🗆 No	200. 200020		,, 000000		
1116	lor Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not l 4 Homicide determined	286. Place	of Injury - At h	nome, larm, si	reet, lactory, or	ffice		281. Location (City or To	Street ar wn, State	nd Number (a)	or Rural	Route Number,
NAME	Hospita 24 hours Funeral tely filled	Medicai C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner: On the ba	best of my knoasis of examination	owledge, dea ation and/or ii	th occurred at the nvestigation, in	the time my opir	, date and place nion, death occu	, and due to the rred at the time,	cause(s date and) and manno d place, and	er as sta I due to	ited. the cause(s)
	To the within 2 To the comple	Me	29b Signature and title of centrior	1					number		29d. Da	te signed (A	Vonth, D	ay, Year)
			1. I'll	the		>	AS	211	385283	3223	1	1241	Dr	
	5		30. Name and address of person who	VAVEN	WE B	ALDI	Print)	, n	ARYL	aud; n	nAK	YE	SU	HU LATES
	St	ate	31. Date liled (Month, Day, Year) 4.	5,32 B	egistra/s Sign	alone /	parks			/				

			1 _ For	State of Maryland			ntal Hygien	e 2001	0061
	*	a	Registrar 1. Decedent's Name (First, Middle,	Last)	Certificate of		Reg. No	× UU4	3. Time of Death
1 2	Physici /Medio	al	NORIS M.	Carlette	AL COLT		Worth 20	2004	4:00/1 M
000	Examin	er	4a. Fecility Name (If not institution, o	1)000 (1.	40. City, Town, o	or Location of Death	9	c. County of Deeth	d
	Funeral Director	ļ	215-09-7789	Sex 7. Age (In yrs. last	birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year Aud 2216	120 Ma	place (State or Foreign intry)
	aryland	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
	r 28e-f	Director	10e. Street and Number	ord Jak	101. Zip Code		10g. C	itizen of What Cou	1 ☐ Yes 2 No intry?
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920	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f ahow valical Extention mast by nutitied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	1 Yes 2 No	Hispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	an, etc.)	Black, White	
21215-0036	na na	Completed	15. Decedent's (Specify only highest	grade completed)	6a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	16b. I	Kind of Business/Ir	ndustry
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Maryland	e d la b	To Be (17. Father's Name (First, Middle, La	Narman		18. Mother's Name (Fi	M. W.	1 Sumame)	
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ore,			20a. Method of Disposition 1 Disputation 2 Cremation 3	□Removal from State ceme	o of Disposition (Name of stery, crematory or other play	Date July	23 20c. L	ocation - City or T	own, State
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	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	omplications that caused the death. End one cause on each line.	a alse P 127	Lane Fres	spiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	ce of):	61 .			
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,	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	ce of):				
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Box 6	death certifica e attending pla e for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3 □Ectopic pregnancy	/		23d. Date of deliver	ery Day Year
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ital		Be Co	25. Was case referred to medical examiner?			26. Place of Death (Cl	1 ☐ Yes 2 № No	1 ☐ Yes	2 No
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sion	Attending is death.	ation	1 SNatural 5 ☐ Pending investigat	(Month, Day Year)	Injury Wor	rk? Yes 2 □ No	occount now inju	19 00001100	
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	To the To the comp	M	29b. Signature and title of certifier	Mn	29c. Licens		29d. Da	ite signed (Month,	
•	15		30. Na and address of person wh	no, completed cause of death (Item 23.		7925	77	17 93	2004
	1		31. Date filed (Month, Day, Year)	32. Registrar's Signature	W. Mach	harl Rd	BelA	il, MI)
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		For	State of Maryland	•		ental Hygier	ne	
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Director		Usual Residence of Decedent	5	7	/	MARCH 15, 1	950 NORT	H CAROLINA
ryland how		10a. State 10b. County	10c. City.	Town or Location		0	1	0d. Inside City Limits
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TOTE, INGLYIGHTO ZIZIOUOOO ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene if filem 27 is marked other than "natural", or items 23a or 28e-f show or other traumetic event, the Modical Examinar must be notified at		19a. Informant's Name/Relationship (Ty ANTWANETTE GROS		19b. Mailing Address (Street		No.		. 21217
tem 2	-	20a. Method of Disposition	20b. Pla	ice of Disposition (Name of metery, crematory or other pla	Da		Location - City or To	
mit. Pages partment of portant: If i y Injury or or		1 ABurial 2 Scremation 3 □F 14 □ Donation 5 □ Other (Specify)		KG MEMORIAL		6-04 W	OODLAW	WMD,
Dalling permit. Page Department of Important: If any Injury or		21. Signature of Funera Service Licens		22. Name and Addr	ass of Facility	PALIJAKI	R. FUNEA	RAJ HOME
D 99 E 8 9			J.I.M	12140 K	1. FULTON	THVE , C	ALTO, HI	02/21/
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The law requires that the death certificate be the has been signed by the attending physicial page 2 should be detached for use as the but	edicai		1	****				
us, r.C. box or or inject the death certifical signed by the attending pld be detached for use as t		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand		44		23d. Date of delive	ery
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at the d by the letach	Phy	9 Unknown Part II. Other significant conditions con		ting in the underlying source gu	won in Part I	23e Did tobacc	o use contribute to th	ne cause of death?
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w requires: been signi	ete	10 1 240 0	SB.	FK ITY		24a. Was an	24b. Were auto	psy findings available
VICAL DEC siclan: The lav certificate has rector, page 2	ompieted	1/2	~D 41	HEONIA		autopsy performed	prior to cor death?	npletion of cause of
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Attand death ctor: y the	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom	ne, farm, street, factory, office			and Number or Rura	l Route Number,
al or /	Certi	4 Homicide	building, etc. (Specify)			City or Town, Sta	ate)	
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the h hin 24 the F	Medi	one)	and manner stated.	29c. Licen:			Date signed (Month, I	
Mil Voi		29b. Signature and title of certifier	18/14/1	7	00005	-4 4	7/90	161
2		30. Name and address of person who co	mpleted spar of death (Item 2	23a) (Type, Print)		1	460	104,
7			J. 132	AXTOR			1 \$	
	tate	31. Date filed (Month, Day, Year) JUL 2 7 2004	32. Registrar's Signatu	sports'				
Regis	trar	JOE 2 1 2004		//				

Leonard Curtis 04-04784 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 July 23, **Physician** Year 0109 A M EONARD KICARDO /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner University Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Days 9 216-08-5036 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Medical Examinar must be invitined at 1 Yes 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 264 AMON Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙇 No Specify: Completed by 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within in and Mental Hygiene.
7 is markad other than "r Elementary/Secondary (0-12) College (1-4or 5+) 10 THGRADE HIGH SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN ပ Pages 1 and 2 should nent of Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itam 27 VETTE AVE BALTIMORE, MD 21225 20a, Method of Disposition Date / 20c. Location - City or Town, State Department of Important: If It any injury or o 1 △Burial 2 □ Cremation 3 □ Removal from State EME 07-29-04 ¹ 4 □ Donation 5 □ Other (Specify) ESTERN STAR CATONSVILLE 21. Signature of Funeral Service Licenses N JR FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine lists cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Examiner death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent cregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached for Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐Unknown page 2 should b Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 □ No certificate 1 Yes 2 🗆 No of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 1 XYes 2 □ No After this c 2X ER/Outpatient 3☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division Hospital or Attending Injury 1 Natural 5 Pending Deceased 12:31 A M 1 ☐ Yes 2 No hours after death. investigation 7/23/04 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 281. Location (Street and Number or Rural Route Number City or Town, State) 3700 Block, Old Fwdenck Rd, Balto, MD 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Frederick Rd. 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and titl 29d. Date signed (Month, Day, Year) O.C.M.E. July 23, 2004 30. Name and address of person who completed cause 3 death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Director 219-01-034B 10 M 2 N F 85 Yrs. Months Days Hours Min. (Months Days No. Dec Dec	
4a. Facility Name (If not institution, give street and number) Stella Maris 5. Social Security Number 219-01-0348 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md. Baltimore 10f. Zip Code 21286 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, et al., puerto Rican, et	th Day Year
Funeral Director 5. Social Security Number 6. Sex 1 Months 1 Mont	4c. County of Death Baltimore
Towson 10a. State 10b. County 10c. City, Town or Location Towson 10c. City, Town or Location Towson 10f. Zip Code 21286 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et al. (1720)	of Birth nth, Day, Year) 9. Birthplace (State or Foreign Country) Maryland
Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Last)	10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country?
The property of the property o	S or No- tc.) 14. Race · American Indian, Black, White, etc.
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g g g g g g g g g g g g g g g g g g g	Own Home Middle, Maiden Sumame)
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route	
For the state of t	Md. 21286 20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State Cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Hillton Service Co. 7-27-04 21. Signature of Funeral Service Licenses Cemetery, crematory or other place) 22. Name and Address of Facility Ruck Towson Funeral	Towson, Md.
23a. Part. Enter the disease or emplication that caused the death. Do not enter the mode of dying, such as cardiac or respire shock, or heart failure. List only one cause on each line. Physician (Madisa) a. INANITION resulting in death)	. Md. 21204
Examiner Sequentially list conditions, if any, leading to immediate but the factor of	
That initiated events resulting in death) Last C. Due to (or as a consequence of): d. Due to (or as a consequence of): 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. Did tobacco use contribute to the cause of death? 1□Yes 2□No 3□Probably 4★Unknown
	. Was an autopsy findings available prior to completion of cause of death? Yes 25 No 1 Yes 2 No
	Residence 6 Cher (Specify) HOSPICE scribe how injury occurred
Logical Paragraph of the Company of	ation (Street and Number or Rural Route Number, or Town, State)
29a. Certifier (Check only (C	to the cause(s) and manner as stated. time, date and place, and due to the cause(s)
D43725	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	7/26/04

FRANCES CARICO

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Req. No. 2. Date of Death 3: Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 8:30 AM July 2004 Cavanaugh Betty June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6424 Lincoln Court Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 5. Social Security Number **Funeral** Months Days Hours Min 1 ☐ M 2 🏋 F Yrs. Aug. 4, 1924 79 Director <u>West Virginia</u> 233-34-8410 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: if tem 27 is marked other then "natural", or itams 23a or 28a-f show ury or other traumatic event, the Markinal Examinar must be notified at ury or other traumatic event, the Markinal Examinar must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State X☐Yes 2☐No Maryland _ Anne Arundel Glen Burnie Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6424 Lincoln Court 21061 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify \$ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 12th Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Tolley RosaLee Stout Marion Gus ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21061 6424 Lincoln Court Judy A. Hanson/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of h Important: If It sny injury or o once. 1 Burial 2 Cremation 3 Removal from State 7/28/2004 * 4 ☐Donation 5 ☐ Other (Specify) Crownsville, Maryland MD Veterans Cemetery 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licensee Homas uanita M00957 1411 Annapolis Road Odenton, Maryland 21113 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MU VPOF Physician /Medical Due to (or as a confequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown should should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? this certificate 2/ No 1 Yes Physician: filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: Certification: To 1 🗌 Yes 2/2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Hospital or Attending 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 0 10 of death (Item 23a) (Type, Print) wo Medurm 32. Regiorar's Signature State 2004

DHMH 17 Rev 1/2001

Registrar

		_	For State Registrar		State of M	aryland		artmen					Rag. N		4	221	51.6
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	Examin			. 1	e street and number)	RII	-0	4b. City,	Town, or	Location		1.0	40	County o	f Death		
	Funeral Director		5. Social Security N 216–12–96	i	`	ge (In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	-	8. Date of B	irth Pay, Year	,	9. Birth	place (State	e or Foreign
7	2		Usual Residence of	Decedent							L	Sept.	Z1,_	1922		ylano	
Aarylar	ranyian F show	៦	10a. State Maryland	10b. County	1		Town or Lo										City Limits es 2 \(\sum \) No
5	r 28a-	irect	10e. Street and Nur	mber				10f. Zip	Code				10g. C	itizen of W	hat Cou	ntry?	
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1215-0036	permit. Pages I and 2 should be hed whilin for hours are bean which he waryan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens. Department of Health and Marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination will be coullined at once.	by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed	ied 2√XMarried 4 □ Divorced	12. Was Decedent Armed Forces 1X2XYes 2 If Yes, Give T Year or Dates	? No		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Or n, Mexica Specify:		acify Yes or N Aican, etc.)	0-		, White,		,
5-0	"natur	eted	(Spec	15. Decedent's E	ducation ade com <i>pleted)</i>		(Give	dent's Usua kind of wor	rk done d	furing mos	st of work	ing	16b. I	Kind of Bus	iness/In	dustry	
21215-0036	iene.	Completed	Elementary/Seco	ndary (0-12)	College (1-4or	5+)		<i>DO NOT</i> us Ochemi		,			U	JS Arı	ny		
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, Mary	and 2 strong salth and N n 27 is mailer trauma		19a. Informant's Na Rosalie		Турө, Print) Wife		444	0 Cly	desd		Avenı		timo	ore, l	Mary	land	21211
Baltimore,	rages I tment of He tant: If iter jury or oth		` 4 □ Donation	☐ Cremation 3 [5 ☐ Other (Speci		Hog	y Red Cemete	natory or of eemer ry	ther place		7/27,	²⁰⁰⁴		.ccation - 0			
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			23a. Part1. Enter t	he disease, or con	nplications that cause one cause on each I	d the death.	Do not en	er the mod	alls e of dying	g, such as	d, Da cardiac	altimor or respiratory	arrest,	laryı	and_	Approxin	nate Between
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8760,	ysiciar be buri	cal E			d												
Box 6	death e atter	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pro						23d. Date Mon		ery Day	Year
<u>α</u> }	requires that the deservice of the sound be detached to	by Ph	Part II. Other signi	ficant conditions	contributing to death I	but not resul	lting in the u	nderlying c	ause give	n in Part I	l,	23e. Did	tobacco	use contri	oute to t	ne cause o	of death?
ords	w require been sig should b											10	Yes 2	10 MG	B 🗌 Prob	ably 4	□Unknown
3ec	has b	Completed										24a. Wa auto	s an opsy formed?	pr	ere auto or to co eath?	psy finding	gs available if cause of
Vital Records,		a	25. Was case refer	rred to medical	<u> </u>					26. Place	e of Deati	1 Tes	2 1 N		Yes	21 No	
f Vi	S S S	To B	examiner? 1 🗌 Yes 2 🖼	-	Hospital: 1 Inpati		R/Outpatier			ar: 4 🗆 Nu	ursing Ho	me 5 Res	idence			y)	
L .	After After fune	:lon:	27. Manner of Dear	th 5 Pending investigation	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time o Injury	f 2	8c. Injury Work	rat ⟨? Yes 2□		28d. Describe	how inju	iry occurre	d		
Division of	or Attending fer death. irector: After n by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In	jury - At hor tc. (Specify)	me, farm, sti					28f. Location City or To			r or Rura	I Route N	umber,
	it of the Hospital of Attending within 24 hours affer death. To the Funeral Director: Affer completely filled in by the funer	Medical Ce	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis of and manner si	of examination	/ledge, deat on and/or in	h occurred vestigation,	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the	a cause(s	s) and man d place, ar	ner as s	tated.	e(s)
	within To the comple	Me	29b. Signature and	I title of certifier	tty4=			1	: License		0			ate signed			
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Physicia	an	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month		Ye	3. Ti	me of Death	
/Medic	al	Charles Patrick								Jul	-4		4 3:	43 P M	
Examin	er	4a. Facility Name (If not institution,				4b. City, To			of Death			County of E			
Funeral		8517 Heathrow C		Age (In yrs.	last birthday)	Nott:	Year	If Under		8. Date of Bir	th	0	ore Co	tate or Foreign	
Director		216-42-2713	1 ™ M 2□F		58 Yrs.	Months	Days	Hours	Min.	Oct 18	, Year) , 194	5 M	Country) aryland	i	
pug .		Usual Residence of Decedent 10a. State 10b. County		10c Cib	y. Town or Lo	cation							tod Inci	de City Limits	
Marylic f sho	ō	MD Baltim	ore		Ltimore								1	Yes 2 ₩o	
1 the 1	Director	10e. Street and Number		Bu.	LCIMOIC	10f. Zip C	ode				10g. Citiz	en of What	t Country?		
th with	al D	8517 Heathrow Co	ourt			2123	6				Unit	ed St	ates		
fore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. at of Health and Mental Hygiene. at of Health and Mental Hygiene. or other traumatic event, the Medical Examination used to redificat	by Funeral	11. Marital Status 1 Newer Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	ent Ever in U. es? No es: 65-66		Vas Deceder f Yes, specific		Spanic Original Mexican Specify:	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)			merican India Vhite, etc.	an,	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. f7 1s marked other then "natural", or traumatic event, the Madical Exami	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4	or 5+)	(Give	lent's Usual kind of work DO NOT use	done di	urina masi	of work	ing	16b. Kin	d of Busine Vatio	ss/Industry		
a filed of Hygie other trent, tr	Be Co	1 2 17. Father's Name (First, Middle, La	st)		rainc	CI		18. Mothe	r's Name	e (First, Middle)	, Maiden S	Sumame)			
ylar buld by Ments arked	To E	Charles Clifton	Carr					Lorra	aine	Unkno	wn				
Mar 12 sh h and 7 is m traum		19a. Informant's Name/Relationship								al Route Numb			e, Zip Code)		
Te, Land Healt Healt tem 2.		Mr. Courtney Carr/Son 1212 Armacost Road, Po 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State											or Town Sta	te	
altimore, rmit. Pages 1 ar partment of Hea portant: if item y injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory									Date Jul 26 200. Location - City or Town, Sta 2004 Beltsville, MD				
Baltimore, Ma permit. Pages 1 and 2 to Department of Health at Important: If time 27 is any injury or other trau		21. Signature of Funeral Service Lic		moe	986 22	. Name and . Cremat	Address 10n	of Facility	y Fune	eral Alt	terna	tives			
Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	ny one cause on each	n line.	n. Do not ente	er the mode	of dying	, such as	cardiac (rrest.		Approx		
/Medical Examiner		resulting in death)	-	as a consequ		CHILL IN		uoin.		OUTELOUIO					
	er	Sequentially list conditions, if any, leading to immediate	b Due to (or	as a consequence of):											
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			insequence of):										
	dical Exa	resulting in death) Last	Due to (or	as a consequ	uence of):										
	In/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregnai		F-+					23	d. Date of	delivery		
P.O. B nat the deat d by the attribitached for	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		t at time of de		Ectopic preg Other (spec						Month	Day	Year	
	by	Part II. Other significant conditions	contributing to deat	h but not resu	Ilting in the ur	derlying cau	se giver	n in Part I.		23e. Did to		,	to the cause Probably 4		
	Completed											24b. Were prior t death	to completion	ngs available of cause of	
Vita sician certifi rector	Be c	25. Was case referred to medical examiner?	Hospital:				Other			Check on o					
hy his	tlon: To	1 X Yes 2 □ No 27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigat	28a. Date of li (Month, i	njury Day Year)	ER/Outpation 28b. Time of Found 3:35		. Injury a Work?	at Nur		me 5 Resid 28d. Describe h Unknown	ow injury		pecify) at	scene	
⇒ affige	Certification;								А	28f. Location (S City or Tow pt.D, N	Street and on State OCCLI MD	3517 °1 18ham	leathr Balt	₩°Ct. imore	
Hospi 14 hou Funer tety fill	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time at the contract of the basis of examination and occurred at the contract of the basis of examination and occurred at the contract of the basis of examination and occurred at the contract of the basis of examination and occurred at the contract of the basis of examination and occurred at the basis of examination and occurred							l place a	and due to the	Pauco/c) a	nd mannor	as stated		
To the within 2 To the complete	ž	29b. Signature and title of certifier	1-011	\			icense i			-	29d. Date :	signed (Mo	nth, Day, Yea	ar)	
1. Tx		30. Name and address of person wh	o completed suse of	of death (Item	23а) (Туре, Г).C.	M.E.			July	23, 2	2004		
		31. Date filed (Month, Day, Year)	10h AV	istrar's Signat	ure .	111	Pen	n Str	æt.	, Balti	more,	Mary	rland_2	21201	
Stat Registra		1111 2 7	2004	strar's Signar	K So	and i									

William Ferebee Unknown 04-251 04-04753 cm**Physic** /Medi Exami Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Ite Medical Exertical trait by rutiliad at once. Baltimore, Maryland 21215-0036 Physician /Medical **Examiner** To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	. Decedent's Name	First Mid	dle lact	+1				te of L	Deali		2. Date of D	Reg. N	ø. U U	14	73	14
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48	a. Facility Name (If	f not instituti	ion, give	street and nu	ımber)		4b. City	y, Town, or	Location	of Death	·	4	c. County	of Death		
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	. Social Security No. 217–90–35		6. Se	x 2 M 2 □ F	7. Age (In y 27	rs. last birthda Yrs.	Months	er 1 Year Days	If Unde Hours	Min.	8. Date of B (Month, D 9-24	irth 2a <i>y, Y</i> ear 1 – 76	r)	9. Birth	place (Stantry) MC	
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	1 ∠Burial 2 L				State	Voshel				7-28	3-04	Du	ndalk	c, Mc	ā.	
2	21. Signature of Fur	neral Service	e Licens	66	,		22. Name a	nd Addres	s of Facil	lity	Bal		re, M		2120	2
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Registrar DHMH 17 Rev 1/2001 JUL 2 7 2004

			1 - For State Registrar	State of M	arylan		artment tificate			nd M	entai Hy	giene Reg. Nø?		235	1.9
	Physici	ian	1. Decedent's Name (First, Middle, CHARLES HERMAN								2. Date of De	Day	Year	3. Time o	
)	/Medic Examir		4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	f Death	2001	2 3 4c. Co	unty of Death	01.00	7€ M
	Zxaiiiii		SINAI HOSPITAL	OF BALTIM	ORE		BAlt	ans	rē	cit	7		N/A		
	Funeral Director		5. Social Security Number 212-01-8578 Usual Residence of Decedent	3. Sex 7. Ag	9e (In yrs. I 86	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, Da 12/7/19	917 917	9. Birthp Cour	place (State of htry) MD	_
	Maryland I-f show	tor	10a. State 10b. County	/A		, Town or Lo	cation						1	0d. Inside C	ity Limits
	ith the or 28s	Director	10e. Street and Number			2110112	10f. Zip	Code				10g. Citizen	of What Cour	ntry?	
	s 23a	rai	2705 JEREMY COU				212					U.S			
5-0036	d within 72 hours after death with the Maryland jene. rr than "natural", or Items 238 or 28s-f show the Madical Evaninar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		1	Vas Decede Yes, speci	_	spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)		Race - Americ Black, White, ec <i>ity:</i> WH]		
N-6171	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5+)	life. L	kind of wor OO NOT use	k doné d e retired)	uring most	of workin	ng		of Business/Inc		
7 0	illed w Hygier other ti	e Col	17. Father's Name (First, Middle, L	ast)		PRUPE	RIETOR	(18 Mother	's Name	(First, Middle		QUOR		
Vian	should be file od Mental Hyg marked othe matic avent,	To Be	LOUIS		F	ELDMAN	ŀ		ANNA	3 142110	() "ot, middle		MICHAEL	.SON	
, Mar	d 2 strauth ar		19a. Informant's Name/Relationshi	SON							Route Numb		wn, State, Zip	Code)	
altimore	ite ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spe		CE	lace of Dispo emetery, crem REI TF	natory or oth	e of her place			/2004		on - City or To		
משונ	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	censee		22	. Name and	Addres	s of Facility	SOL	LEVINS	SON & E	BROS.,	INC.	
	40140		23a. Part1. Enter the disease, or c	omplications that caused	the death								ILLE, M	Approximat	
+	Physician /Medical Examiner		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	Due to (or as	a consequ	ience of):								Interval Bet Onset and I	ween Death
	ped sit	niner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Advance Due to for as	a consaço	enge of):		SUM	Tive	pul	yeron	dise	HC		
,0070	cate be executed bhysiclan and the burial-transit	dical Examiner	that initiated events resulting in death) Last	c. Due to (or as			>								
O. DOX 0	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Or the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as sompletely filled in by the funeral director, page 2 should be detached for use as sompletely filled in by the funeral director.	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pre Other (spe						Date of delive Month	,	/ear
ביאסוס	quires tha n signed I uld be det		Part II. Other significant condition ConにES つくこ +	s contributing to death b	ut not resu しんモ		derlying cal		n in Part I.			obacco use c Yes 2 □ No	ontribute to th	e cause of d ably 4 □U	
מישב =	Physician: The law rec this certificate has bee al director, page 2 shoo	Completed by	CARDIOMYOPATH	1 , Consus	RY	ALTE	24	8/15	AJE		24a. Was autor perio 1 Yes	rmed2	death?	osy findings and pletion of ca	available ause of
VII.a	nician certific rector	Be	25. Was case referred to medical examiner?	Hospital:				Othor			Check only o				
5	ding Phys h. After this funeral di	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju. (Month, Date		ER/Outpatient 28b. Time of Injury		c. Injury Work	4 🗀 IAUI2	28	e 5 Resid		Other (Specify curred)	
	al or Attending Is after death. Il Director: After ad in by the funer	Certification;	3 Suicide 6 Could no 4 Homicide determin	be 200 Bloom of Init	ury - At hor c. (Specify)	me, farm, stre	et, factory,				Bf. Location (S City or Tov	Street and Nu vn, State)	mber or Rurai	Route Num	ber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred at estigation, i	t the time in my opi	e, date and nion, death	place, ar occurred	nd due to the	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s))
	To the To the Complet	Z	29b. Signature and title of certifier	W M.	۵.		_	License		00		29d. Date sig	ned (Month, E	2004	
	10		30. Name and address of person with PAOLO TABR		eath (Item	23a) (Type, F		< 20 H	ITAL	r	F BA	HLTIM	1005		
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Pegistra	ar's Signati	1	Son								

			State of Maryland / Departme		ental Hygier	ne	_
12	1196	4	Registrar 1. Decedent's Name (First, Middle, Last)	ate of Death	Reg. I	No.2	2 3 5 5 0 3. Time of Death
	Physici /Medio		Myrtle K. Glaccum		Month 07/2	Day Year J/2004	08:35 AM
}	Examir	er	4a. Facility Namb (If not institution, give street and number) ROCK GLED DURSING HOME	ity, Town, or Location of Death ALTI MORE	=	4c. County of Death	
	Funeral Director	157			8. Date of Birth (Month, Day, Yea 4-20-/	9. Birthp.	- 1 - m
3	yiand Mow		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		/	11	Od. Inside City Limits
	188-1 st	Director	MD BALTIMORE Caton				1 ☐ Yes 2 No
	23a or	ai Dir	10e. Street and Number 1917 Clifden Rol	21228	10g. (Citizen of What Coun	try?
0	Items Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Marned 1 Yes 2 No	cedent of Hispanic Origin? (Spec pecify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - America Black, White, 6	
9036	ral', or	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes or Dates:	2 DNo Specify:		Specify: W	rite.
215-(illed within 7.2 flours after beath with the maryland Hygiene. the riben'hen'astural', or Items 23a or 28a-f show ant, tre Medical Examiner mant be notified at	Completed	life DO NO	work done during most of working	16b.	Kind of Business/Ind	lustry
212	her tha	Com	Elementary/Secondary (0-12) College (1-4or 5+)	2.5		Jothin	G
Maryland 21215-0036	2 E D S	To Be	Harry Habbs Kessler	Grace	B. Waid	n bold	/
Man	ith and I		19a. Informant's N. e/Relationship (Type, Print) 19b. Mailing Addr. 19c. Mailing Addr. 19c. Mailing Addr.	ess (Street and Number or Rural	Route Number, City	or Town, State, Zip	Code)
ore, l	or other		20a. Method of Disposition 1 Burial 2 Octemation 3 Removal from State 20b. Place of Disposition (cemelent, cremajory of	Varne of Day other place)	ate 20c.	ocation - City or Tox	wn, State
altimore,	E 60 3		EVANS FUNER	ACCHAPTET 1-2.		prest Hi	
Balt	Departm Imports any nju		Kim Very J. Zavrotau PEACE	and Address of Facility 2325			UM, MOZO EMATION CT
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the management shock, or heart failule. List only one cause on each line.	ode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	netion_			
a	xaminer	<u>_</u>	Sequentially list conditions, b. Another conditions, but to (or as a context unice of):	1			
Patter	nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ed down			
8760,	sician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
687	ng physi	Medical	d				
ROX	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1			23d. Date of deliver	y Day Year
	by the	Physi	9 ☐ Unknown				
VITAL RECORDS, P.O. BOX 68760, icien: The law requires that the death cardificate he executed	been signed t	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying	; cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
Hecc he law r	e has be	Completed			24a. Was an autopsy performed?	24b. Were autop: prior to com death?	sy findings available pletion of cause of
		Be Co	25. Was case referred to medical examiner?	26. Place of Death (1 ☐ Yes 2 € N (Check only one)	o 1 ☐ Yes 2	!□ No
OT V	er this c	7: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 = 27. Manner of Death 1 ENatural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year) 1 Injury		e 5 Residence		
DIVISION For Attending	eath. Ior: Afte the fun	catio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Work? 1 ☐ Yes 2 ☐ No	· ·		
	after d f Direct d in by	Certification;	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	ory, office 28	3f. Location (Street a City or Town, Sta	ind Number or Rural (e)	Route Number,
e Hospit	within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, I	edicai (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.	id at the time, date and place, an on, in my opinion, death occurred	nd due to the cause(f at the time, date ar	s) and manner as sta nd place, and due to t	ted. he cause(s)
Toth	within To th comp	Me	29b. Signature and title of certifier	9c. License number		ate signed (Month, Da	
	6		30. Name and address pers in who is mpleted cause of death (Item 23a) (Type, Print)	D47800	1 0	7/27/21	204
	·		30. Name and address pers in who impleted cause of death (Item 23a) (Type, Print) 16 Abendeen Plane Mendeen 31 Pate filed (Abenth Deu York)	MA	21001		
	Sta Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature Benura	Sparks			

DHMH 17 Rev 1/2001

Registrar

2004

ELIZABETH GUNNING

ORIGINAL

JUL Z 7 2004

			1 - For Stete Registrar	State of Man		artment of H		lental H		000	1	205	F 0
			Decedent's Name (First, Middle, Last	<u> </u>		imouto or i	Douth	2. Date of I			Lå	3. Time (of Death
	Physic /Medi		Albert Anthony	Gurney				July 2		ay 2004	Year	7:25	РМ
	Exami		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death			c. County	of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
			Gilchrist Center			Towson				Bal	timor	ce	
	Funeral		5. Social Security Number 6. Se	ZM SUE	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of E	Day, Yea	r)	9. Birthp Coun	lace (State try)	or Foreign
	Director		215-24-1035 Usual Residence of Decedent	7!	5 '''			June	16,	1929	Ma:	rylan	<u>d</u>
	ryland how		10a. State 10b. County	10	c. City, Town or Lo	cation					11	0d. Inside (
	e Ma	ctor	MD Harford		Jarret	tsville						1 🗍 Yes	2 X No
	or 2	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of V	Vhat Coun	try?	
\leq	sath v	Fra	1504 North Bend R	oad 12. Was Decedent Eve		21084					Stat		
8	fter d	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?	11	Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	Rican, etc.)	No-		e · Americ k, White, e		
735pm	Ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	KOTE GIT	☐ Yes 2☐ No	Specify:			Specify	: Whi	.te	
()	I Z I 3-UU36 within 72 hours after death with the Maryland ene. than "natural, or Items 23a or 28e-f show he Mudical Executar rust be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)		ent's Usual Occupa	ation during most of worki	ina	16b.	Kind of Bu	siness/Ind	dustry	
9	Mithin ham a series	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	OO NOT use retired	()	, , <u>, , , , , , , , , , , , , , , , , </u>	Ir			nal Pa	per
00	be filed value Hygie of other t	ပ္ပိ	12 17. Father's Name (First, Middle, Last)		Pressn	nan	18. Mother's Name	(First Midd	lle Maide		Compa	апу	
Q	d be ental ked o	To Be	Albert Gurney				Helen	Kris		n Sumam	θ)		
3	Maryland 21215-UU36 Id 2 should be filed within 72 hours alf this and Mantal Hygiene. It is marked other than "natural", or treaumatic event, the Modical Exert	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailin	g Address (Street a	and Number or Rura			or Town,	State, Zip	Code)	
		1	Bernice Gurney/w	ife	1504		end Road	Jarre				210	184
50	SALLIMOTE, Dermit. Pages 1 ar Department of Hea mportant: If item; any injury or other ange.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Dispos cemetery, crem			ate	20c. l	ocation -	City or Tov	wn, State	
L.	FIM Pag tment tant: jury c	Н	`4 □ Denation 5 🗴 Other (Specify)	Entombment			Mem Grans	/ 2004	Ti	.moni	⊔m, M	Maryla	ınd
Sg.	Dall permit. Departr Importa any inji		21. Signature of Fineral Service Licens	99		Name and Addres	IΛU	ck Tou	son	Fune:	ral H	lome,	Inc.
OU.	_ 405.60		23a. Part1. Enter the disease, or compl	ications that gaused the		150 York		son, M	Maryl	and			
23			shock, or heart failure. List only o	ne cause on each line.	death. Do not ente	i the mode of dying	g, such as cardiac o	respiratory	arrest,			Approxima Interval Be Onset and	tween
	Fnysician /Medical		disease or condition resulting in death)	Due to (or as a co	Canc	es						year	2
	Examiner				nisoquonico (ii).								
٧١	. p .≡	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a no	nisecuanda off:								
•	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
10	be ex ician i			Due to (or as a co	insequence of);								
U	phys the	edical		1							-		
0	eath certific attending p		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p						23d Date	of deliver	v	
6	death death e atte	Physiclan/M	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		Ectopic pregnancy Other <i>(specify)</i>				Моп			Year
3)	that the de ed by the a	hys	9 🗆 Unknown	9□ Unknown					Ì				
1-35-04(requires that the death certification is signed by the attending rould be detached for use as	b	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the un	derlying cause give	on in Part I.					cause of o)
best 07-35-0	w requir been si should l	Completed						1	Yes 2	. L. No	3 Proba	ibly 4	Inknown
0.00	The law rate has be	nple						24a. Wa auto	opsy	DI	rior to com	sy findings pletion of c	available ause of
0 =	vital nec stcian: The law certificate has t irector, page 2 s							1 ☐ Yes	formed? 2 X No	1	eath? □Yes 2	2□ No	
ない	Physician: This certific al director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	4 T F B 10	3CI DOA Othe	26. Place of Death					10.00	
DE		n: To	27. Manner of D ath	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient 28b. Time of	28c. Injury	at 2	ne 5∐Res !8d. Describe		6 Othe		Alcoh	CE
7	Attending F r death. sctor: After by the funering	atlo	1 Destural 5 ☐ Pending investigation	(Month, Day Ye	ar) Injury	Work M 1 □ Y	? ′es 2 □No						
M. Sold	l or Attendater deatl	tific	3 Suicide 6 Could not be determined	28e. Place of Injury · building, etc. (S	At home, farm, stre	et, factory, office	2	8f. Location	(Street ar	nd Numbe	r or Rural	Route Num	ber,
2	ital or urs afte ral Dir	Cer											
Sureney, Albert	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical Certification:	(Check only 2 Medical Examination)	ner: On the basis of exa and manner stated.	y knowledge, death mination and/or inve	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the	e cause(s , date an) and man d place, a	ner as sta nd due to t	ted. the cause(s)
9	o the	Mec	29b. Signature and title of certifier	and manner stated.		29c. License					(Month, D		
	⊢s⊢ō		Midnand	nm		De	X 207		100	y 2	6 2	004	
	1	1	30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, P	rint)	0 30-7	1		1		/	
	IVA		Aron Charler	no 6	001 N.	Charles	Sti	3alti	nove	n	92	1204	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	1	<i>)</i> ,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 Godwin Ju₁y 4:15 A Agnes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Oct. 9, Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** 1 □ M 2**X** F 84 Director 214-24-1971 Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Glen Burnie Anne Arundel Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 U.S.A. 483 Renfro Court Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 ANo filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within 7. Department of Heelih and Mental Hygiene. Important: If item 27 is marked other then "na eny injury or other treumatic event, the Media 2008. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Caroline R. Puffer Joseph Prince ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 483 Renfro Court, Glen Burnie, MD 21060 Mrs. Margaret Silva / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery Jul 26,2004 Brooklyn, MD ' 4 Benation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licensee 1 Second Avenue S.W., Glen Burnie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition STROKE **Physician** years resulting in death) /Medical Due to (or as a consequence of): Examiner neumon 19 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physicien Be Completed by Physician/Medical as the l use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year detached for 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown á 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, should be 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No. 24a. Was an autopsy performe this certificate 1 Yes 2 110 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 1 10 Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funerel E 1 [Destifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Gorbat

Year)

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31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wille Day JULY A. Gill yare 6:18 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES HEALTHCARE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** 10M 20F Days Hours Year 167-32-3088 mg vst 28, 1946 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ont: If Item 27 Is marked other than "naturel", or Items 23a or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show treumatic event, it a Madical Examinar must be notified all 10d. Inside City Limits Baltimore 1 Ves 2 No Completed by Funeral Director Timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 70 Blac 3 ☐ Widowed 4 ☐ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Julius Gillyar heresa 19a. Informant's Name/Relationship ype, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stale, Zip Code) Buttomore Item 27 ls other tre Gillyan ESSEX MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State emetery, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Importent: If any injury or once. Memorial Punk 7/30/04 * 4 ☐ Donation 5 ☐ Other (Specity) 21. Signature of Funeral Service License Funeral Service, P. 4 Bultimore MD ZIZNI-1922 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERVALEMIA Physician HOUPE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DAYS METABOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed anding physicien and use as the burial-transit DAYS AWIE RENAL FAILURE Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE 3 Probably 4 □Unknown LUNG CANCER 1 ☐ Yes 2 ☐ No funeral director, page 2 should 15 CHEMIC CARDIOMYOFATHY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed HEPATIC ENCEPHALOPATHY 2 No Division of Vital 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: Certification: To 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation within 24 hours after deatl To the Funerel Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MURTAZA HAZMI, M.D -17610 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURTAZA KAZMI M.D 900 S CATON AVE, BACHMORE, MD 21229 ST.AGNES itUSPITAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 2 7 2004 Registrar

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		. [Decedent's Name (First, Middle, L.)	ast)					2. Date of Deat Month		3. Time of Death
	Physici /Medic		Jane Beverly	Hill	July 22		12:35 AM				
	Examir		4a. Facility Name (If not institution, g	ive street and r	number)		4b. City, Town, or	Location of De	ath	4c. County of Dea	ath
			1105 Parthenor		7 4 4		Bel If Under 1 Year	Air If Under 24 H	ro o p (B)	Harf	
	Funeral			Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. Ia	a <i>st birtnd</i> ay) ¬ Yrs.	Months Days	Hours M	n. (Month, Day,	Year) 9.80	irthplace (State or Foreign Country) District Columbia
	Director		216-11-2240 Usual Residence of Decedent		/	1			Nov. 11	l, 1926 of	COLUMBIA
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-f si	ctor	Maryland Montgom	ery	Roc	kville	9				1 ☐ Yes 2 🐼 No
	or 28	Directo	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	Country?
	ath w		4700 Tallahass				208			USA	
	ltem Item	Funerai	11. Marital Status 1 Never Married 2 Married	Armed	ecedent Ever in U.5 Forces? s 2 ∰No	5. 13.	was Decedent of His f Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh	
5	d within 72 hours efter death with the Maryland liene. I than "natural", or Hems 23a or 28a-f show If a Medical Examinational be mailfied at	by	3 ∰Widowed 4 □ Divorced	If Yes,	Give Dates:		1 ☐ Yes 2 🖾 No	Specify:	Specify:	White	
2-0036	2 hou		15. Decedent's	Education	dl	16a. Dece	dent's Usual Occupa kind of work done d	ation	and in a	16b. Kind of Busines	s/Industry
Z	withIn 7 ene. than "r	nple	(Specify only highest of Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired))	rorking		
V	illed will Hyglen other th	Completed			2	Home	emaker			Own H	ome
and	d ta b	Be	17. Father's Name (First, Middle, La Harvey Winter		Sr			Elsi	lame <i>(First, Middle, M</i> e Irene	Wollett	
Ξ	should ind Men imarke	2	Harvey Winter 19a. Informant's Name/Relationship	Payne,	DI.	10h Mailie	a Address (Street o			City or Town, State,	Tin Code I
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ā,	1 and Health tem 27 other to		Robert H. Hill, 20a. Method of Disposition	Jr.	20b. Pl		Partnenor sition (Name of natory or other place			Maryland 20c. Location - City o	
ē	ages ant of at: If i		1 ☐ Burial 2 🌠 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		m State		natory or other place Service Co	ı	-23-04	l'owson, Ma	ryland
saltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Fyneral Service Lic		1111				Home, P.A.		Lytana
ñ	Ded Imp		Delle Mil	may-	Kon-		Accomas Fu	ineral :	Home, P.A.	don, MD 2	1009
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	/Medical		resulting in death)		to (or as a consequ		1 Tygico	, ,			,
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	be tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a consequ	ence of):					
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X Q Q	requires thet the death certific een signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregnar		Ectopic pregnancy			23d. Date of de	,
	deat	sicia	in the past 12 months? 1 Yes 2 No		gnant at time of de		Other (specify)			Month	Day Year
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s,	v requires thet the death been signed by the atte should be detached for	by	Part II. Other significant conditions		death but not resu	itting in the u	nderlying cause give	in in Part I.	23e. Did tob	1.7	to the cause of death? Probably 4 Unknown
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VItal		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	☐Inpatient 2☐E	ER/Outpatier	othe	_	eath (Check only on		Conla
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UIVISION	Atte ecto by th	ifica	3 Suicide 6 Could not determine	be 28e. Pla	ice of Injury - At hor ilding, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number or F	Rural Route Number,
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	t hour	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physicien: To taminer: On the	the best of my know basis of examinati	wledge, deat	n occurred at the tim	e, date and pla	ce, and due to the ca	ause(s) and manner a ate and place, and du	as stated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medi	one)	and m	anner stated.		29c. License				, ,
	7 × 10 × 10 × 10 × 10 × 10 × 10 × 10 × 1	-	29b. Signature and title of certifier	0.1	Chris			_		9d. Date signed (Mon	
	0		Mac M. De	yu	ause of death (Item	220) (T	•		•	Vuly CZ	accep
	3		30. Name and address of person who have the same and address of person and address of person and address of person address of person and address of person address of	1			ING ST	NW	Wastin	July 22	20010
	Sta	ate	31. Date filed (Month, Day, Year)	32	. Registrar's Signat						
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Registrar DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** JIMMIR Harbor 1845 M 07 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of 5. Social Security Number Un Baltimore If Under 1 Year If Under 24 Hrs. Baltimore 7. Age (In yrs. last birthday) 9. Birthplace (State of Foreign Funeral Days 1**X** M 2□ F South Carolina 63 Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or Itams 23a or 28a-f shov Examiner coust be notified at MD Prince George's Forestville 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2602 Ritchie Road 20<u>747</u> Funerai Pages 1 and 2 should be filed within 72 hours after death USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1X Never Married 2 ☐ Married 1 XYes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 *natural, or 1 ☐ Yes 2 No þ Specify: black 3 Widowed 4 Divorced f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, Ins Madical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk College (1-4or 5+) Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Harbor Rosa Heard P of Health and N Item 27 Is mai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Robert Heard/step brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ò 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or * 4 ☐ Donation 5 📉 Other (Specify) in stat/e 21. Signature of Euneral Service sicensee Ronald Warde, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 DUC essen 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebra Hemorrhage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sua to for se a consecuence off-Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ţō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy perform certificate 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To this the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 1 Natural 5 Pending death. 4 hours after death. Funerel Director: / 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certifier 29c. License number AU417643515230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREEN ST. JOHN ARIAI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 30 PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimore Cer anda If Under 1 **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 163-10-4608 1 □ M 2 X F Director sylvania Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "natural", or Items 23e or 28e-f show treumatic event, it a Medical Examiner must be notified at 1 XYes 2 □ No Directo Marviand more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 402 2 Funeral O 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? 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Location - City or Town, State 5 <u>=</u> 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place permit. Page Department of Importent: If any injury or once. 2004 Ridge Cem ruid 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Joseph L. Russ 1-2222 W. North Ave. uneral Home Baito, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the derying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performed? Vital 20 1 🗌 Yes 2□ No 1 Yes Hospitel or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death Check only one) examiner Other: 2 1 🗌 Yes 20 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Hursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Matural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 2 7 2004 Registra

			For 1 State	State of Maryland	d / Department of F Certificate of			2006	23559
			* Registrar	aet)	Certificate of	Dealli	2. Date of Death	g. No: UU	
	Physicia	an	Decedent's Name (First, Middle, L.	L. Jones	,		Month	Day Year	3. Time of Death (ルル とんと) M
	/Medic		Ethel			or Location of Death	JULY.	21 2009 4c. County of Deat	
	Examin	er	4a. Facility Name (If not institution, gr				Dr.	4c. County of Deal	^
			5. Social Security Number 6.	Sex 7. Age (In yrs. la		ALTIMO If Under 24 Hrs.	8. Date of Birth	9 Birt	pplace (State or Foreign
	Funeral		115-17-4/71	1 □ M 2 🗖 F	2 Yrs. Months Days	Hours Min.	Month, Day, DEC - 28,	Year Co	untry) CAROLISIA
	Director		Usual Residence of Decedent	0.			ucc. as,	1720 NOF	THE CHECKING
	land ow		10a. State 10b. County	10c. City,	, Town or Location				10d. Inside City Limits
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	death with the Maryland ms 23a or 28e-f show r.must be notified at	Directo	10e. Sheet and Number		10f. Zip Code	_/.//.		Citizen of What Co	untry?
	3a or	<u>a</u>	3911 11)AR	ASH AVE AF	TIB.	2121:	5	USA	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S		Hispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	rican Indian,
0	r Ite	Fū	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗷 No			Hican, etc.)	Black, White	e, etc.
3	hours after turel', or Ite	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No	Specify:		Specify:	LACK
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Maryland	_ 0 5	Be	17. Father's Name (First, Middle, Las	it)) t	18. Mother's Name		laiden Sumame)	,
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a	2 sho and Is m		19a. Informant's Name/Relationship		19b. Mailing Address (Street				
	s 1 and 2 should of Health and Mer item 27 Is marke other treumatic		KEITH DROWN	GREAT NEPHEW)					MB, 21108
ore			20a. Method of Disposition Burial 2 □ Cremation 3	Demoval from State	ace of Disposition (Name of emetery, crematory or other pla	ice)		0c. Location - City or	Iown, State
Itimore,	permit. Pages Department of I Importent: If it any injury or o		' 4 ☐ Donation 5 ☐ Other (Spec	ity) KIA	IG MEMORIAL PA	RK 107-2	8-04 4	WOOLAWA	MARYLAND
Q	Departi Departi Import any inj		21. Signature of Furieral Service Lic		Name and Addr	of Facility B	ROWN	R. FUNE	CAL HOME
<u> </u>	997 29		· UN), IOVVC	~2140 N	. FULTOI	UAVE.	BALTO, M.	0,21217
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. ly one cause on each line.	. Do not enter the mode of dyi	ng, such as cardiac o	or respiratory frre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CO	rongry site	ery disc	ea se		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ					
	Examiner		Coquentially list conditions	b	ypertens	ION			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying						
	nd rans	Examiner	Cause (Disease or injury that initiated events		Instable A	1249			
Ó,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a consequ		(m)			
3760		Ilcai		dO_S	teosatint	. >			
9	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE:						
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1☐Live birth 2☐Fetal	death 3 Ectopic pregnand	÷y		23d. Date of del Month	very Day Year
0	he dea	sici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5 Other (specify)				,
<u>a</u> .	d by	Phy	Part II. Other significant conditions	contributing to dooth but not recu	ulting in the underlying eques as	von in Part I	23a Did tob	acco use contribute to	the cause of death?
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ec	ne law has b ge 2 sl	npie					24a. Was an autopsy	prior to o	topsy findings available completion of cause of
=	The	Completed					perform 1 Yes 2	ed? death? ■No 1 ☐ Yes	2 X No
/ita	Attending Physicien: The law requires that the death certifica rideath. ector: After this certificate has been signed by the attending phythe funeral director, page 2 should be detached for use as it by the funeral director, page 2.	Be	25. Was case referred to medical examiner?	Monitoli		26. Place of Death	(Check only one)	_
Division of Vital	Phyei this c al dire	P	1 ☐ Yes 2 X No		EH/Outpatient 3 DOA			nce 6 Other (Spec	cify)
Ē	ding P	on:	27. Manner of Death 1 ★ Natural 5 Pending	(Month, Day Year)	28b. Time of 28c. Injury Wo		28d. Describe ho	w injury occurred	
Sio	ttendii death. ctor: A y the fu	cati	2 Accident investigat 3 Suicide 6 Could not	the l	M 1 [me, farm, street, factory, office	Yes 2 No	20/ 1		
\leq	or Attencater death	Certification:	4 Homicide determine	eet and Number or Ru State)	irai Houte Number,				
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	To the Hospitel within 24 hours a To the Funerel I completely filled	edical		Physician: To the best of my know aminer: On the basis of examinati and manner stated.					
	thin 2 the mple	Mec	29b. Signature and title of certifier	and mariner stated.	29c. Licen	se number	29	d. Date signed (Monti	h, Day, Year)
	F × F S		N TO	>		0115		7/26/4	
	,		10						
	5		30. Name and address of person wh	o completed cause of death (Item	DUISONY !	HCTS MYCO	= R911	Imore m	021215
			31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture				
	Sta Regist		111 2 7 200		& Sparker	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Georgie L. Jenkins 11:30 PM July 19 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A 418 Freeman Street Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Y)
Dec. 18, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthptace (State or Foreign **Funeral** Year) 1909 Virginia 218 18 8762 94 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 U.S. 418 Freeman Street or items 23a Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify N Yes, Give Year or Dates: Completed by 3 XWidowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if Item 27 Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Shoemaker Shoe Factory 10th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be George Pullin Unknown 2 other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Jenkins son 203 Edison Street Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If Ite any injury or of ODGE. 1 Deurial 2 Cremation 3 Removal from State Cedar Hill Cemetery 7/23/2004 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerat Service.Li 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or conshock, or heart failure. Use only Approximate Intervat Betw Immediate Cause (Finat disease or condition **Physician** /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit Due to (or as a consequence of) the attending physician IF FEMALE: . If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23b. Was decedent pregpant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Hesidence 6 □Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Waturat Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records. To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: filled in by completely

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

aute of death Mem 23a) Type.

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dey, Year)

20,200

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Clifton Reed Johnson JULY 04:34P M /Medical 18, 2004 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 27, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**⊋**M 2□ F 68 Director 216-32-1791 1935 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Bel Air Harford Director Maryland 1 Yes 2 ANO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 1314 Scottsdale Drive, Unit R USA or flems 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: þ Specify 3 Widowed 4 Divorced Year or Dates natural', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ring most of working Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Military other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F Reed Clifton Johnson Ruth Bernice Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1314 Scottsdale Drive, Unit R, Bel Air, MD 21015 nt of Health a: If item 27 is Janis Johnson/Wife other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit, Pages 1
Department of H
Important: If itel
eny injury or ott 20c. Location - City or Town, State t

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8-9-2004 Arlington National Arlington, VA pf Funeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. (OMOS) 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disasse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) nmediate Cause (Final Physician MYOCARDIAL INFARCTION UNKNOWN /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNKNOWN Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit DIABETES MELLITUS UNKNOWN Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, CONGESTIVE HEART FAILURE, CHRONIC RESPIRATORY FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? ANOXIC ENCEPHALOPATHY 24a. Was an page 2 autopsy performed? of Vital 1 ☐ Yes 2 X No 2 \(\text{No} \) Hospital or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🕱 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 XNatural Injury 1 ☐ Yes 2 ☐ No after death investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 🗌 Homicide filled within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D24648 JULY 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 SHER A. HASHMI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 7 2004

DHIVIF 17 Nev 1/200

Registrar

KNOWN TO PHYSICIAN: JOHNSON, CLIFTON

NAME

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health at Certificate of Death		giene Reg. NQ:	P (1) P =
			Decedent's Name (First, Middle, Last)	2. Dete of Dec	eth CUUH	-3. Time of Death
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of Birt	th y, Yeer) 9. Bi	rthplace (State or Foreign
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	or 28e-f	je je	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	country?
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Maryland	12 should be f n end Mental ! is marked of iraumatic eve		19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number	or Rurel Route Numbe	or, City or Town, State,	Zip Code)
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Ö	s after s afte	Ser	building, etc. (<i>Specify</i>)	City of Town	n, Siele/	
	L hour uners	Medical Certification: To	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred et the time, date and p	lace, and due to the coccurred at the time, d	euse(s) and manner e	s stated.
	the H hin 24 the F nplet	B	one) and manner stated.			
	To To cor		29b. Signature and title of certifier PRIMART CARE 29c. License number D005394		Pod. Date signed (Mont	
	2	1				00-1
	0		30. Name end address of person who completed cause of death (Item 23e) (Type, Print) James Tansinda 300 Armory	Place Sy	ute Balto	Mdzizai
	Sta	e	James Ian Sinda 300 AT MOTY 31. Date filed (Month, Day, Year) 32. Registrar's Signeture	TIME 4	n Lallo	1114.61.201
	Registra		JUL 2 7 2004 Jane 13 Jane			

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene perinf, 6834 Dertificate of Death State
Ragistrar Amend item#5, Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ande /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTI YNO RE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) 1es St ot 204 4100 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 218⁵344 0507 **Funeral** 1 M 2 F Months 7Yrs. 6 Director da an Oil Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE Directo MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 4100 N. 04.204 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 UNO
If Yes, Give Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) JUNER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 Is marked oth any injury or other treumatic event once. Be TRANCES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 12 1 19a. Informant's Name/Relationship (Type, Print) 4100 N. Charles St. Apt. 204 BALTINGRE MD and Disposition (Name of Dispo Kandel -husband uton 20b. Place of Disposition (Name of cometery, crymatory of other place)

EVANSFUNERAL (HAPEL - 7-27-04 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) FOREST HIL 22. Name and Address of Facility 2325 YORK RD. TIMON IUM ME 2109 PLACEFUL ALTERNATIVES FUNCEAL TERMATION CTR 21. Signature of Funeral Service Ligensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, in shock, or heart failure. List eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Cel Immediate Cause (Fin Carcihoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner Attending Physicien: The law requires that the death certificate be executed burial-transit ding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 **A** No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Fesidence 6 Other (Specify) 2 No Hospital: Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funerel Director: After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04

10

Registrar

31. Date filed (Month, Day, Year)

C-Clowse Ms. 67

Day, Year)

JUL 2 7 2004

Server

Server

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Charles St Rm 5105 Baltimure NO 21704

		State of Maryland	-	ment of F ficate of		_				
	Decedant's Nama (First, Middle, Last)		00/11/	reate or	Dodin	2. Data of De	ath 200	3. Time of Death		
Physician /Medical		George T. Kr	July	22 20	7aar 1004 2:25 P.M.					
Examiner										
e.,	5. Social Sacurity Number 6. Sax			Me Under 1 Year	Annapol If Undar 24 Hrs.			ne Arundel		
Funeral Director	181 03 1065 ^{1X}	M 2□F 88	Yrs.	lonths Days	Hours Min.	8. Data of Bir (Month, Da Feb. 3	, 1916	D. Birthplace (State or Foraign Country) Pennsylvania		
M =	Usual Rasidance of Decedant 10a. Stata 10b. County	10c. City	, Town or Locati	ion				10d. Insida City Limits		
Important: If fem 27 is marked other than "natural", or flems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Maryland Anne Ar	ındel Ar	napolis	3				1 ☐ Yas 2X No		
i e	10e. Street and Number			10f. Zip Code			10g. Citizan of Wh	at Country?		
를 를	35 Milkshake Lan	е		2140	03		U.S.			
by Funeral Director	11. Marital Status 1 ☐ Naver Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Dacedant Ever in U,\$ Armad Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas:	}	Decedant of Hes, specify Cuba Yas 212 No	lispanic Origin? (S) an, Maxican, Puart Spacify:	pacify Yas or No Pican, atc.)	Black,	American Indian, Whita, atc. White		
eted	15. Decedant's Edu (Spacify only highast grade	cation complatad)	16a. Decedent	's Usual Occup d of work dona	ation during most of work	king	16b. Kind of Busin	ness/Industry		
Completed by	Elamantary/Secondary (0-12) 6th	College (1-4or 5+)	lifa. DO	NOTusa retired LCal Ope	3)	Grace (Chemical			
BeC	17. Father's Nama (First, Middla, Last)	`					Maiden Sumama)			
To	George K	riskie			Ann	ie Piho	nick			
	19a. Informant's Nama/Ralationship (Ty	·			ar, City or Town, St					
	Steven Kriskie /		1		ven Drive	Data		Maryland 21060		
	20a. Mathod of Disposition 1 ဩ Burial 2 ☐ Cramation 3 ☐ R 4 ☐ Donation 5 ☐ Othar (Spacify)	Gle	ace of Disposition matary, cramato n Haven	Mem. P	ark	7/27/04		rnie, Maryland		
eny in	21. Signature of Funeral Service License	muculs		ama and Addra 1 Ritch	ie Highwa	once Fun ay Bal		vice, P.A. Maryland 21225		
	23a. Part1. Entar tha disa 5 or compli shock, or haart failura. List only or					or respiratory a	rrest,	Approximate Interval Batwaen Onsat and Death		
ical	Immediata Causa (Final		50~5×	er at	fut			300		
iner	disaasa or condition rasulting in death)		as a consequar					3.1		
ine.										
edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequer	ice of).						
se es the bunel-transit Medical Examír	that initiated events resulting in death) Last	Due to (or								
Iclan	Dart II. Other elemidians conditions con	tribution to death but not recul	22h Did	lahasas usa santri	buta to the causa of death?					
d be detached for use e	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							☐ Probably 4 ☐ Unknown		
2 shoul							an autopsy rmad?	24b. Wara autopsy findings availabla prior to completion of causa of death?		
director, pega						101	ras 2 no	1 ☐ Yes 2 ☐ No		
Be (25. Was casa refarred to medical axaminar?				26. Placa of Dea	th (Check only o	na)			
ral dire	1 Tes 2 LUNO		· · · · · · · · · · · · · · · · · · ·	3□ DOA Oth	4 Derrursing H		dance 6 □Othar	(Spacify)		
funera ion:	27. Manner of Death 1 → Natural 5 □ Pending	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injur Wor M 1	yat k? Yas 2 □ No	28d. Describe h	now injury occurrad			
completely filled in by the funeral Medical Certification: 1	2 Accidant invastigation 3 Suicida 6 Could not be 4 Homicide datarmined	28e. Place of Injury - At hor building, atc. (Specify,	28f. Location (S City or Tox		or Rural Routa Numbar,					
edicai C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examirone)	ician: To the best of my know ar: On tha basis of axaminati and mannar statad.	rledge, death oc on and/or invast	curred at the tir igation, in my o	ne, date and place, pinion, death occur	and due to the rad at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)		
Completely filled in by the fune Medical Certification	29b. Signatura and tilla of certifier			29c. Licans	a number		29d. Date signed (I	1		
	> 7) () Xne			13	2636		2/33	10004		
7	30. Name and addrass of person who co	mpleted causa of death (Itam	23a) (Type, Prin		19 Oru	u Ch	21 km m	0 2/4/9		
State	31. Date filad (Month, Day, Yaar)	32. Ragistrar's Signati	ura	. 42 0 04	•					
Registrar	.1111 2 7 201	14 Genera	B	Some	61					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** July 3:15p м 2004 Peter Krohn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Quail Run If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 77 Yrs. 213-28-5853 Germany Director 21, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28a-1 ehow any injury or other traumatic event, the Modical Examiner ruth by Incitified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 THES 2 No Completed by Funeral Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3928 Yolando Road 21218 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ♥Yes 2 □ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates: Konea Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Transportation Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Krohn Johanna Reichmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Arena/Niece 3928 Yolando Road, Baltiomre, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jul 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 26 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 2004 Beltsville, MD 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licen: 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 01 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tran 68760. the attending physician Physician/Medicai for use as the Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, funeral director, page 2 should be 3 Probably 4 Denknown 1 ☐ Yes 2 ☐ No Be Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has autopsy performed? 1 ☐ Yes 2 D NO or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 To her (Specify) assisted living 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After Injury 1 Waturat 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier chmpletely (Check only one) 29b. Signatule and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Imme and address of pirson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

	For State Registrar	State of Maryla	•	rtment of H		R	eg. N.C. 0 ()	4 2356	56		
Physician /Medical	PHYLLIS FRANCE Facility Name (If not institution, give	S KAISS		4b. City, Town, or	Location of Death	2. Date of Dea Month	Day	Year 9 30 of Death	Peath		
Examiner Funeral Director	UGSBURG LUTHERA ocial Security Number 6.5 9-22-0930	N HOME Sex 7. Age (In yi	rs. last birthday) _ 00 Yrs.	GWYNN O If Under 1 Year Months Days		8. Date of Birth (Month, Day 11/04/1	BALTI		r Forei		
s or 28s-f show be notified at Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MARYLAND ANNE ARUNDEL LINTHICUM							10d. Inside City 1 ☐ Yes	1		
r items 23a or 28a-f s binar must be notified Funeral Director	Street and Number 5 GREEN TREE RO	AD		10f. Zip Code 21090		1	What Country?				
Extender on Latendar on Latendar of Latendar of Latend	Marital Status 1 □ Never Married 2 □ Married 3 🛣 Widowed 4 □ Divorced	lf lf	fas Decedent of H Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE					
Hygiene. other than "natural", o ent, the Mountal Exam ent, the Mountal Exam e. Completed by	15. Decedent's E (Specify only highest gr. dementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+) N/A	(Give k	ent's Usual Occup ind of work done o O NOT use retired STRESS	ation during most of work 1)	ing	16b. Kind of Bu	PPENHEIMER			
Be Sent	Father's Name (First, Middle, Last RANK PERRY		10h Mailie	Address (Street	18. Mother's Name LAURA and Number or Run						
filem 27 is maring of them trauma	a. Informant's Name/Relationship (R. HENRY KAISS Method of Disposition	(SON)	6215	WOODLANI	ROAD, L	INTHICUM	, MARYL	AND 21090 City or Town, State			
Important: If item 27 is marke any injury or other traumatic once.	201. Method of Disposition X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Other (Specify) 21. Signature of Funeral Service Licensee M00303 22. Name and Address of Facility S INGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MARYI										
physician and state of the purial-transit and control of the physician and	a. Part1. Enter the disease, of conshook, or heart failure. List only mediate Cause (Final ease or condition ulting in death) quentially list conditions, hy, leading to immediate ise. Enter Underlying use (Disease or injury trinitiated events ulting in death) Last	a	Escheward sequence of):	it cav	g, such as cardiac d'omyope ey disc		est.	Approximate Interval Between Onset and Draws	Seath		
d by the attending pheterached for use as the letached for use as the Physician/Med	EMALE: . Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 → No 9 ☐ Unknown		23d. Date Mor	e of delivery nth Day Ye	'ear						
should be a	II. Other significant conditions	en in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow 24a. Was an 24b. Were autopsy findings availab								
	Was case referred to medical				26. Place of Deat		No 1	refer autopsy findings a refer to completion of carleath? Yes 25 No			
fter this ce ineral direc on; To E	examiner? 1 Yes 2 No Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Wor	er: 4 Nursing Ho		ence 6 Othe				
To the Funeral Director: After t completely filled in by the funera Medical Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num City or Town, State))e <i>r</i> ,		
the Funer impletely fill	a. Certifier to Certifying Pi (Check only one) 2 Medical Exa	nysician: To the best of my k miner: On the basis of exami and manner stated.	ination and/or invi	estigation, in my or	pinion, death occurr	ed at the time, di	ate and place, a	and due to the cause(s)			
Toth	o. Signature and title of certifier	×		29c. Licenso	a number 737573 sterston	2	9d. Date signed	(Month, Day, Year)			
	Name and address of person why Sef Zibell Date filed (Month, Day, Year)	completed cause of death (I	lem 23a) (Type, F	it Rei	stieusten	~ Mt	5112	36			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year /Medical ERNESTINE KING July 14,2004 <u>6:5</u>9am[™] 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cherry Lane Nursing Home Laure1 Prince Georges If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours 1□M 25F Director 578-36-4245 Yrs 76 March 2,1928 Wilson, NC Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ir items 23e or 28a-f shov direr must be nutified at MD Prince Georges Director Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4746 68th Ave Completed by Funeral 20784 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "neturel; or item eny injury or other treumetic event, Ite Madfall Examined. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Claims Processor Govt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earnest Davis Effie Bullock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Douglas /Daughter 4746 68th Ave, Hyattsville, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 7-21-04 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Texander S. Pope Funeral HOme aloria ave 2617 Penn.Ave S.E. Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiomyapathy /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any leading to mind cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4☐ Pregnant at time of death Month Day 5 Other (specify) o 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Diabetes Mellitus Type II Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1 Yes 2X) No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 1 July 15,2004 n 30. Name and address of person who completed cause of/death (Item 23a) (Type, Print) 9001 Cherry Lane, Laurel, MD 20708 Alan R. Segal M.D. 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar IUL 2 7 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 JÜĽŸ KLAFF 23, SARAH 1:01 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6511 WICKFIELD ROAD BALTIMORE BALTIMORE Hours Min. 8. Date of Birth (Month, Day, Year) 05/21/1913 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2**V**2 F 228-38-9735 91 Yrs Director RUSSIA Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23s or 28s-f show 1 Yes 2 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6511 WICKFIELD ROAD 21209 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify ģ If Yes, Give Year or Dates: Specify. 3 XWidowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nnt: If item 27 Is marked other than 1ry or other traumatic event, 11s Mg Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, PHILIP BEL OV RACHEL MOGALENSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL KLAFF / SON 6511 WICKFIELD RD. BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury or 1 X Burial 2 ☐ Cremation 3 X Removal from State permit. Page Department of Important: If any injury or once. 07/25/2004 DANVILLE, VA. 4 ☐ Donation 5 ☐ Other (Specify) AETZ CHAIM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 EMOURA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician INFARCTION # CUTE MYOCARDIAL MINURS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed as the burial-transit Due to (or as a consequence of): of Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes mellitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown AIZHZIMERS DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ANEMIA 1 ☐ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 5 Pending investigation after death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number D30377 July 23, 04 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6503 PARIL BALT. MD MO ROBERT M. COOPER HEIGHTS 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra JUL 2 7 2004 sporks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY **Physician** 22, 2004 LILLIAN I. KAROLKOWSKI 1:30 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HERITAGE GENESIS ELDERCARE DUNDALK BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 12/12/ Funeral 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🔀 F MARYLAND Director 215-09-5403 86 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits orient: If item 27 is marked other then "neturel", or items 23a or 28a-1 show injury or other treumatic event, the Medical Examinar must be notified at Director 1 X Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 GUSRYAN STREET 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filled within nent of Health and Mental Hygiene. int: If Item 27 is marked other then " College (1-4or 5+) Elementary/Secondary (0-12) OUALITY ASSURANCE CONTINENTAL CAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANK ETMANSKI LUCY CZAKUSKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA FORNEY 3368 BRANTLEY CT. DAUGHTER GLENWOOD, MD. 21738 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State tment tent: HOLY ROSARY CEME. 7/26/04 ' 4 ☐ Donation 5 ☐ Other (Specify) DUNDALK, MD. 21. Signature of Funeral Service Lic-Departi Import any inj once KACZOROWSKI FaciFUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 23a. Part1. Enter the disease, or confrications that caused the defith. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or it art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner WAR the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the t IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has autopsy 2 DNo 1 Yes I or Attending Physicien: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 217 No Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Director; After 1 Natural
2 Accident 5 Pending investigation 1 🗌 Yes 2 🗆 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funeral L 1 Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the dause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number Who completed cause of dea

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signati

			State of Maryland / Departs		•	•
			FOI	iicate of Death		0001
			Registrar 1. Decedent's Name (First, Middle, Last)	icate of Death	Reg. N	3. Time of Death
	Physici		Charles & loof			Day Year - 1
	/Medic Examir		A = 100 At 100 max to all all a form of an all and an all and an all and an all all all all all all all all all	o. City, Town, or Location of Death		Ic. County of Death
	2.xaiiii		Wesley Home	BALTIMOR	E	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		016-01-0986		1-14/19	13 Pennsylvania
	land W		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits
	Mary -f shi	ō	E MN ROLT	IMORE		1 Yes 2 □ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	h with	ai D	2211 W. Rogers Ave.	21209		USA
	be filed within 72 hours after death with the Maryland tal Hygiene. dother than "natural", or flems 23e or 28e-f show event. the Medical Examinar must be redified at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces?	Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
36	or it	by Fu	1 Never Married 2 Married 1 Yes 2 No	Yes 21 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: h
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/lai		70	Charles H. Lect	Mar	u E. Ro	hl
Maryland	2 sho and I is me			ddress (Street and Number or Ru	ra/Route Number, City	or Town, State, Zip Code)
	24 tr		Charles F. Daughaday 2901A.	Conkry Ct, B	ALTIMORE	, MD 21234
lore			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, crematory.	CRALCHAPEL 7-6	- 1	Location - City or Town, State
Baltimore,			' 4 □ Donation 5 □ Other (Specify) EUANS FUNE 21. Signature of Funeral Service Licendee 22. Na	RALCHAPEL- 1-0	19-04 F	DREST HILL, MA
Ba	Departr Departr Importe any inju		Les les les la	ame and Address of Facility	TIMORE,	MD 21234
			23a. Part1. Enter the disease complications that caused this distant. Do not enter the shock, or heart failure. It only one cruse on each line.	ne mode of dying, such as cardiac	or respiratory arrest,	800 HARFORD PA). Approximate
	Physician		Immediate Cause (Final	- Failing		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):			
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Ξ	Physician: r this cartific ral director.	o Be	examiner?	0.1	th (Check only one) ome 5 - Residence	6 Other (Specific)
of	ding Phy h. After this funeral o	n: T		28c. Injury at Work?	28d. Describe how inj	
ior	andin sath. or: Aff	atlo	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No		
Division	ol or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)	factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
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	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edicai	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occ (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation one)	curred at the time, date and place, gation, in my opinion, death occur	and due to the cause(red at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	ro the	Me	29b. Signature and title of cegifier	29c. License number	29d. D	ate signed (Month, Day, Year)
			R.t. Fileto, Ms.	D21464	7	1/27/04
	IND		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	t)		
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			1 - For State Registrar	State of Maryland / Depart	artment of Health and Natificate of Death	Mental Hygie	_	23571
	Dhysia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physic /Medi		Mary Louise	Lauinger		July =	Day Year	4 2:05PM
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
			Genesis Eldercare		Catonsville		Baltim	ore
	Funeral		5. Social Security Number 6. Sec.	7	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	g. Bir	thplace (State or Foreign buntry)
	Director		212-01-3953	92 Yrs.		(Month, Day, Ye Apr. 27,	1912 Ma	ryĺand
	and		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
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	with Fe or	ä	6115 Ďavis Road				. Citizen of What Co	
	leath	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. 13. V	21797	noity Von as No	United St	
10	r Her	臣	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖫 No	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
936	ers a	by	3 XWidowed 4 □ Divorced		☐ Yes 21X No Specify:		Specify:	White
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215	within 7 ene. then "n	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+) (Give life. L	kind of work done during most of work DO NOT use retired)	king		,
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	be filed tal Hygid d other event, Il	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	den Sumame)	
/lai	should be nd Mental marked o	2	Frederick Garlin		Christi	na Olsen		
Maryland	da Em	ľ	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Mailin	g Address (Street and Number or Rui	al Route Number, Ci	ity or Town, State, 2	Zip Code)
	permit. Pages 1 and 2 Department of Health s Importent: If item 27 is eny injury or other tre once.		Lois Ann McGee - Da	aughter 100 Jo	nes Road Chester	. Marylan	d 21619	
Baltimore,	of He roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Dispos			. Location - City or	Town, State
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	rate be executed white burial-transit the burial-tr	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Lists of incorping Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	or the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deli	very Day Year
٦	res that signed b be deta	by Pr	Part II. Other significant conditions cor	atributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
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- 44	Sta Registr	-	31. Date filed (Month, Day, Year) JUL 2 7 2004	32. Registrar's Signature	land.			1-

			1 - For State Registrar	State of M	arylar		artmen rtificate			and M		Reg. No.	001	,	2357	2
Н	Physici	an	Decedent's Name (First, Middle, L								2. Date of De Month	eath Day	Ye	ar	3. Time of Dea	ith
	/Medic		Robert Wesl								July	21,) 4	11:05	рМ
	Examin	er	4a. Facility Name (If not institution, g)				Location o	of Death		4c.	County of I			
			7527 Browns Brid			f	If Under	ghlai		0.4 Usa			Howar			
	Funeral Director		5. Social Security Number 233-30-0142 Usual Residence of Decedent	. Sex 7. Ad 1	90	last birthday) Yrs.	Months	Days	If Under: Hours	Min.	8. Date of Bir (Month, Da Aug. 2	th ay, Year) 19	1.3	Birthpi Count Ohio	ace (State or Fo try) O	reign
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	3a or		7527 Browns Bridge Road 20777 USA										,			
	ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U	I.S. 13.	Was Deced	ent of His	spanic Orig	gin? (Spe	ecify Yes or No		14. Race - /			
9	after or Ita	Fur	Amed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 Married 1			ver in U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto					Rican, etc.)		Black, V	Vhite, e	etc.	
5-0036	rel', c	i by	3 Widowed 4 Divorced			1 ☐ Yes 2	M71M0	Specify:			Specify: White					
2	be filed within 72 hours after deeth with the Maryland ital Hygiene. d other then "naturel", or Itams 23s or 28s-f show event, I'm Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of			(Give	dent's Usua kind of wor	k done d	urina most	of worki	na	16b. Kir	nd of Busin	ess/Ind	ustry	
2	ithin 96.		Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired)			3				/ 1	,
2	filed withi Hygiene. other then	S	Grade 8	0		Oper	ating					l		101	n (roads	;)
Maryland 21	Mental Mental arked c	To Be	17. Father's Name (First, Middle, Last) John E. Lewis 18. Mother's Name (First, Middle, Maiden Sumame) Sarah L. Cochran													
<u>ā</u>	2 sho and Is m		19a. Informant's Name/Relationship								Il Route Numb					
	1 and 2 Heelth Iem 27 I		Isabel Lewis /	spouse	1005 5		Brow		riage				d, MD		0777	
altimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition XXBurial 2 ☐ Cremation 3	☐Removal from State	0	Place of Dispo cemetery, crer	natory or of	ther place	´		ate	20c. Loc	cation - City	or Tov	vn, State	
Ē	tmen tent: jury	1	* 4 □ Donation 5 □ Other (Spec	cify)	Mt	Zion U							ghlan	1, f	Maryland	1
gal	permit. Pages 1 Department of H Importent: If Iten any injury or ott		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of):										Approximate Interval Between Onset and Death Years			
8/60,	death certificate be executed e attending physician and sd for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.													
٥	ng ph as th	Medi	IF FEMALE:													
O. Box	the death ce the attendi	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown							2	23d. Date of delivery Month Day Year				
7	n requires that the de been signed by the should be detached		Part II. Other significant conditions	contributing to death t	out not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco us	e contribut	e to the	cause of death	?
SD	quire n sign	d by									1XX	Yes 2□]No 3□] Proba	bly 4 🗆 Unkno	own
ecords	law requires that the as been signed by th 2 should be detache	Completed									24a. Was		24b. Were	autop	sy findings availa	able
r	The ate h	E O									perfo	rmed?	death	i? /es }	pletion of cause √∑ No	OI
Vital	yelclen: This certificate director, pag	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only o					
010	d is	2	1 ☐ Yes 2 🛣 XNo	Hospital: 1 Inpati		ER/Outpatien	t 3 DO	A Other	r: 4 🗆 Nur	sing Hor	ne 5 XX Resio	dence 6	Other (5	Specify)		
	ding Ph h. After th funeral	.ii	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry y Year)	28b. Time of Injury	28	3c. Injury Work	at ?		28d. Describe I					
20	endi eath. or: A he fu	Satt	2 Accident investigati	ion			М		es 2 □ N	10						
DIVISION	s efter du s efter du al Direct ad in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (5 City or Tox		Number or	Rural	Route Number,	
	To the Hospitel or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying F	Physician: To the best aminer: On the basis of and manner st	if examina	wiedge, death tion and/or inv	occurred a vestigation,	at the time in my opi	e, date and nion, deat	d place, a	and due to the ed at the time,	cause(s) a date and p	and manner place, and	as sta	ted. he cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier	0			29c.	. License	number			29d. Date	signed (M	onth, D	ay, Year)	
	. 0		Kamil	, と, 1分。	-P-	_ ~	CI	D 3	6371			Ju	ıly 22	2, 2	2004	
	10		30. Name and address of person wh													
			Raymond E. Banfe			orman	Road	Lau	rel,	Mary	land	20723	3			
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2	7 2004 > A			4	1								

			1 - For State Registrar	State of Mar	-	artment o				iene •9. NĢ []	n I.	23572
	Physici	an i	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day	Year	3. Time of Dealth
	/Medic		Mark Anthony Lest						JULY		2004	9:40 PM
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Tov					y of Death	
			St. Agnes Hospita 5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Y	Baltim ear If Unc	lore der 24 Hrs.	8. Date of Birth		/A 9. Birth	place (State or Foreign
	Funeral Director			M 2□F	48 Yrs.	Months D	ays Hou	rs Min.	(Month, Day, Aug. 17	, 1955	Cou	yland
	and and		10a. State 10b. County		10c. City, Town or Lo	cation						10d. Inside City Limits
	Mary -f sh	ţō	MD Balti	more		Lanso	lowne					1 ☐ Yes 2 🙀 No
	r 28a	irec	10e. Street and Number			10f. Zip Co	de		10	Og. Citizen of	What Cou	ntry?
	23a o	Funeral Director	7 Ridge Avenue				2122	.7		Unite	d Sta	tes
	ams ams	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent	of Hispanic Cuban, Mexi	Origin? (Spican, Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri	can Indian, etc.
9	s 1 and 2 should be liled within /2 hours after death with the Maryland if Health and Mental Hygiene. If the 21 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, the Medical Exampler must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1□ Yes 2X				1	_{fy:} Whi	
ה ה	in 72 ho "natur tedical	Completed	15. Decedent's Edi (Specify only highest grad	le completed)	(Give	dent's Usual O kind of work d DO NOT use re	oné during n	nost of work	ing	16b. Kind of E	Business/In	dustry
7 7	iene.	luo	Elementary/Secondary (0-12)	College (1-4or 5+)		Machini	İst			Westi	nghou	se
2	otha vant,	a)	17. Father's Name (First, Middle, Last)				18. Mc	other's Name	e (First, Middle, N	laiden Suma	me)	
<u> </u>	uld by Menta Irkad Itic e	To B	Gilbert L. Lester				V	eroni	ca E. Do	niecki		
<u>g</u>	2 Should ba filed within and Mental Hygiene. 7 Is marked other than "I traumatic evant, I'm Medical Internation of the Medical In	ľ	19a. Informant's Name/Relationship (T	γρe, Print)	19b. Mailir	ng Address (St	reet and Nur	mber or Run	al Route Number,	City or Town	, State, Zip	Code)
	and and n 27 n 27 nar tra			on				Y	owne, MD			
5	Fagas 1 nent of H int: If ital iry or oth	-	20a. Method of Disposition 1 Burial 2 Cremation 3 1	Removal from State	20b. Place of Dispo cametery, crar Meadowrid	natory or other OE	place)			20c. Location	•	
	tant:		□ Donation 5 □ Other (Specify,	000	Memorial	Park			-2004	Elkri		
ם מ	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra 900.8		21. Signature of Funeral Service Licens	Tan Und	INVIOLY				Rd., La			Lansdowne
-	4.5		23a. Part1. El ter the disease, or comp	lications that caused th	ne death. On not ent						-, IID	Approximate Interval Between
	husisian		shock, or heart failure. List only of Immediate Cause (Final				Ca.					Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Due to (or as a	IRATOR consequence of):	7	ALL	URE			-	HUURS
1	Examiner		Conventing the link and distance	PNEU	NONIA							DAYS
	n ≃	ner	Sequentially list conditions, it any luant to immediate cause. Enter Underlying Cause (Disease or injury	Tue to (or as a	consequence of):							
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):	· · · · · · · · · · · · · · · · · · ·						
000	cate be executed physician and the burial-transit	ai E		Due to (or as a t	consequence or,							
00	physicate sthe	dicai		d								
Υ :	death certifica a attending ph d for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. Da	ate of delive	erv
<u> </u>	a atter	ciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir		Ectopic pregn Other (specif					onth	Day Year
	t me c by the acher	hys	9 Unknown	9□ Unknown								
'n	Ina law requires mat me deam certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause	e given in Pa	art I.				ne cause of death?
	equir en si ould l	ted							1 🗌 Ye	s 2 No	3 Prob	pably 4 Unknown
ני	as be	Completed							24a. Was an	24b.	Were auto	psy findings available mpletion of cause of
ב י	Ina ate h page	Son							perform	ed?	death? 1 ☐ Yes	2 No
= =	ertific actor,	Be	25. Was case referred to medical examiner?	taranta b 1					(Check only one	-		
5	nysi this o	မ	TU Yes 24 No	lnpatient					me 5 Resider			y)
	After After funer	ion	27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day)	(ear) 28b. Time of Injury		Injury at Work? 1 □ Yes 2		28d. Describe hor	w injury occur	rea	
2	death ctor: y the	ficat	3 Suicide 6 Could not be	28e. Place of Injury	/ - At home, farm, str		_		28f. Location (Str		ber or Rura	d Route Number,
2	after Dira	Certification;	4 Homicide	building, etc.	(Specify)				City or Town,	State)		
	to the nospital or Attanding Priystcian: The law requires that the death cer within 24 hours after the services. The the Lunaral Director. After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	edical (29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of ner: On the basis of e and manner state	xamination and/or inv	occurred at the	ne time, date my opinion, d	and place, death occurr	and due to the ca ed at the time, da	use(s) and m te and place,	anner as s and due to	tated. the cause(s)
-	o tha o tha omple	Mec	29b. Signature and title of certifier			29c. Lic	cense numbe	er	29	d. Date signe	d (Month,	Day, Year)
1	- s ⊢ ŏ		Liber 1	smaila M	Telosin	P	186	5/9		TuLY	20	2004
	6		30. Name and address of person who c	ompleted cause of dea	ith (Item 23a) (Type,	Print)	10			/		2.2-1/-
			ISMAILA JIBRIN	, MD, S	Jubrin hth (Item 23a) (Type, TAGNES	HEAL	THC	ARE,	BALTI	MORE	, m	021229
75	Sta	tė	31. Date filed (Month, Day, Year)	ar. negistiai	s Signature							

Physici		Decedent's Name (First, Midd	fle, Last)							2. Date of De			3. Time of Dea
- /Medic		Elizabeth	N. M	1cClure						Month July	Day 17	2004	par
Examir		4a. Facility Name (If not institution	on, give street and	number)		4b. City,	Town, or	Location of	of Death			ounty of E	
		Shady Grove A	dventist	Hospita1	-	F	Rockv	7i11e				Mon	tgomery
Funeral Director		5. Social Security Number 214–48–5793	6. Sex 1 ☐ M 2 🕅 F	7. Age (In yrs. 54	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug. 2	th ly, Year)	9. 9 N	Birthplace (State or Fo Country) lichigan
*		Usual Residence of Decedent 10a. State 10b. Count	v	10c. Cit	ty. Town or Lo	ocation		1			,		
ust be nutified at	tor		gomery		.,, , , , , , , , , , , , , , , , , , ,		erma	ıntowi	n				10d. Inside City Li 1 ☐ Yes 2 ∑
or 28e-f	Director	10e. Street and Number	<u> </u>			10f. Zip			-		10g. Citize	n of What	t Country?
23e		13417 Walnut	wood Lane	2			20	874			Uni	ted S	States
or Items	Funeral	11. Marital Status	Armed	ecedent Ever in U. Forces?	.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 14	. Race - A	American Indian, Vhite, etc.
Depolarisation to results and waited in Trygenes. Internet is of terms any injury or other treumetic event, it is Medical Exemined: Once.	þ	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 💢 Divorce	If Yes,	s 2 🕅 No Give r Dates:		1 ☐ Yes 2						pecify:	White
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ed of	Be	17. Father's Name (First, Middle	McCluro	s T. McC	lure					e (First, Middle,		,	
mark	٦ ا	19a. Informant's Name/Relation		•	10h Mailie	a Addross	(Ctroot o	KU	ıth	1 Daniel March	Gi1ma	an	
27 Is r treu		Mary McClure-	~	Step- Mother	3142	Grac	efie	na Numbe 1d Rá	rorHura I. ∦N	17 Houte Numbe 17 - 513	Silar, City or I	own, Stat	e, Zip Code) 2090 ring, MD
item		20a. Method of Disposition		20b. P	Place of Dispo	sition (Nam	ne of			Date			or Town, State
iry or		1 ☐ 8urial 2 X Cremation 1 ☐ Donation 5 ☐ Other		m state	esapeal	-		· 1 1	uly ₂	234	Be1t	svil	le, MD
Importe any inju		21. Signature of Funeral Service	Licer	w f				-		emation			
: E 29 91				10						ver Spr			20910
- 6		23a. Part1. Enter the disease, o shock, or heart failure. Lis	t only one cause or	it caused the death n each line	n. Do not ent	er the mode	e of dying	, such as	cardiac _, o	r respiratory ar	rest,		Approximate Interval Between
eician -		Immediate Cause (Final disease or condition		110									HISTORY DRIMAGE
odical-		ropultion in donth	a.	/riyo	card	ral	/	nfar	ctio	n			Onset and Death
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11:45 PM Elizabeth Angeline Metzger MIY 04 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2**S**F Days Min Months Hours 89 Yrs. 218-09-3165 1914 Maryland Oct 23, Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside, City Limits 10b. County 10a, State or 28e-f show the Medical Examiner must be notified at 11 Yes 2 □ No N/A Baltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 708 E. 37th Street United States Ната 23а filed within 72 hours after deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Neyer Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: 3 Widowed 4 □ Divorced Completed by Year or Dates: White 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Own Home Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Peges 1 and 2 should be filed ment of Health end Mentel Hygis ant: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Peter Poos Bertha Bouchet 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 Department of Health e Important: If Item 27 is any injury or other trai Ms. Karen Metzger/Daughter 708 E. 37th Street, Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jul 26 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State Beltsville, MD Chesapeake Crematory 2004 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives c890au ulit 8717 Green Pastures Drive Baltimore, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Heart fordure /Medical Due to (or as a consequence of): ID Year **Examiner** diseaso cownavy onter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit or Attending Physician: The law requires thet the death certificate be executed Hypertens an and Due to or as a consequence of). P.O. Box 68760, the attending physician hed for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes ₽ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? has certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ M6 Medical Certification: To this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation **1** □ Natural М 1 □ Yes 2 □ No death. 2 Accident filled in by the Director 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after 24 hours a Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) completely To the ! within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CRD RSQ1 AT2438946 M.D. 07/22/04 3501, ST PAUL STREET, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olsai Dr Chaitanya BALTIMORE- 21218, ND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			101	epartment of Health and Certificate of Death	Mental Hygier	2001 2000
	Physic	ian	1. Decedent's Name (First, Middle, Last) William S. McKir		2. Oate of Death Month	2004 3. Time of Death
	/Medi Exami		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		2004 12:38 PM 4c. County of Death
		М	4218 Manor View Road	Glen Arm		Baltimore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 7. 4	nday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) Maryland
	land DW		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	h the Marylar r 28a-f show	ctor	Md. Baltimore Glen	Arm		1 ☐ Yes 2X No
	with the	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	death ms 23	Funeral	4218 Manor View Road 11. Marital Status 12. Was Decedent Ever in U.S.	21057 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	USA 14. Race - American Indian,
920	hours after death with the Maryland tural, or items 23a or 28a-f show at Exemples must be notified at	þ	1 ☐ Never Married 2 ◯X Married 1 ☐ Yes 2 ☐ No If Yes Give Year or Dates:	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 🛣 No Specify:	to Rican, etc.)	Black, White, etc. Specify: White
15-0	72 hour "natural"	eted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of wo	rking 16b.	Kind of Business/Industry
Maryland 21215-0036	d withir giene. or then tre Me	Completed	Elementary/Secondary (0-12) College 31-4or 5+)	life. DO NOT use retired)	A	uto Repairs
pug	i 2 should be fited wan and Mental Hygier is marked other tiraumatic event, the	Be	17. Father's Name (First, Middle, Last) Leon McKin		me (First, Middle, Maide	
aryle	should nd Mer marke	²		Mailing Address (Street and Number or Ri	ural Route Number, City	Butler
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, important: If Item 27 is marked other than iny injury or other traumatic event, Item 2008.		Mrs. Etta McKim/ Wife	218 Manor View Road		
Baltimore,	permit. Pages 1 and Department of Health Importsnt: If Item 27 any injury or other to	9	Contract State of the contract	Disposition (Name of crematory or other place)		Location - City or Town, State
altin	permit. Pag Department Importsnt: Imp injury o		21. Signature of Foreit Septific Licensee	p Service Co. 7-24		owson, Md. 21204
8	Depa Impo Any is		Tarelle Hagain	22. Name and Address of Facility Ruck Towson Fund 1050 York Rd. To	owson, Md.	21204
0,	Physician /Medical Examiner phi/sician and phi/sician and phi/sician and phi/sician items it is useful to the phi/sician and p	Examiner	Due to tor as a consequence of	ZESPIRATORY DISTRUCTINE PUL DISTRUCTINE PUL	FAILU	
8760,	icate bi physici s the bu	dical	d			
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ords, P.	w requires that been signed I should be det	þ	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	¥.	use contribute to the cause of death?
Vital Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 2 Yes 2 No
Vit	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1	Other	th (Check only one)	6 □Other (Specify)
ion of	ding After fune	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Inj	ne of 28c. Injury at	28d. Describe how inju	
Division	ospitel or Attending hours after death. unerel Director: Aftei ly filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	s, street, factory, office	28f. Location (Street a. City or Town, Stat	nd Number or Rural Route Number, e)
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause(s red at the time, date an	s) and manner as stated. d place, and due to the cause(s)
	Total Comp		29b. Signature and title of certifier waryles from A	10. D19589		ate signed (Month, Day, Year) - 20 - 0 4
	0		30. Name and address of person who completed cause of death (Item 23a) (TEVAN CELVS C. LIGNOS 7801	YORK Rd TOW		
	Sta Registra	10	31. Date filed (Month, Day, Year) 32. Registrar's Signature Server	5 Sparks		
DHM	AH 17 Rev 1/20	001		- porter		

ORIGINAL

			State of Maryland / Department of H 1- State Amend Item 11,12 per Inf., G834, 08/06/04			23577
		,	Decedent's Name (First, Middle, Last)	2. Date Mor	e of Death	3. Time of Death
	Physici		Alonzo Allen McCormick		1v 24 2004	4:00 P M
	/Medic Examir			r Location of Death	4c. County of Death	
	LAGIIII		5 Oak Street Edgewo	ood	Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8, Date	e of Birth 9, Birth	nplace (State or Foreign untry) LNOIS
	Director		350-24-7285 ¹\(\overline{X}\) M 2 \(\overline{F}\) 73 Yrs. Months Days	May	10, 1931 III	inois
	9		Usual Residence of Decedent			104 India Obitini
	show		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	Director	Maryland Harford Edgewood			
	or 2	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	23a	rai	5 Oak Street 21040		USA	
	tems er m	ne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Specify Yean, Mexican, Puerto Rican, e	s or No- etc.) 14. Race - Ame Black, White	
36	or i	by Funeral	1 Never Married 2 Married 1 See 2 No 1950 1 Yes 2 No	Specify:	Specify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show to Medical Exeminer must be notified at		15. Decedent's Education 16a. Decedent's Usual Occup	nation	16b. Kind of Business/	inte
5	"nat	Completed	(Specify only highest grade completed) (Give kind of work done	during most of working	TOD. ICARC OF DESIRESS	maustry
12	withi ene. than	ш	Elementary/Secondary (0-12) College (1-4or 5+) Communication		U.S. Govern	ment
	filed withi Hygiene. othar than ant, Ite M		17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Sumame)	
an	Mental Merkad o	o Be	Ralph (nmn) McCormick	Fern Mai	rie Derry	
Maryland	should ind Men s marka umatic	2		and Number or Rural Route	Number, City or Town, State, Z	(ip Code)
Ma	d 2 sho th and t7 is ma traum				Maryland 21085	
ė,	ges 1 and 2 should be filed within 72 hours atter death with the Marylan It of Health and Mental Hygiene. If itiam 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic avent. The Medical Engrine must be notified at		20a Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	Town, State
Baltimore,	permit, Pages Department of Important: If it any injury or o once.		1 XBurial 2 □ Cramation 3 □ Removal from State 1 Dorfation 5 □ Other (Specify) Arlington National		4 Arlington	Virginia
Ē					as Funeral Home	
Ba	permit. Departr Importa any inju				oingdon, Maryla	
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying			Approximate
и			shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
	Physician			ASTUO ENTE	BIINAL BL	EED
	/Medical Examiner		Due to (or as a consequence of):			
н		-	Sequentially list conditions, b. Circo 1403; S. Liu e	- A		
	ed sit	Jine	Sequentially list conditions, I arry, leading to with collater cause. Enter Underlying Cause (Disease or injury			
	and and	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
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687	phys the		d			
	ding se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli	ven.
Вох	atten for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1	1	Month	Day Year
	the de	ysic	1 Yes 2 No 9 Unknown			
P.0	The law requires that the death certifica to has been signed by the attending phroage 2 should be detached for use as the	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ren in Part I. 23	e. Did tobacco use contribute to	the cause of death?
Records,	w requires that been signed to should be det	i by			1 Yes 2 No 3 Pro	obably 4 Winknown
O	requ	Completed			lii lau w	
Jec	a law has t e 2 s	npi			a. Was an autopsy performed? 24b. Were au prior to death?	topsy findings available completion of cause of
H		Co		1	Yes 2 No 1 ☐ Yes	2[XNo
Vital	Physician: The law r this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec		
)	> 0 0	2	1 XYes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	4 Nursing Home 5	Residence 6 Other (Spec	cify)
Division of	fte file	Certification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury Wo	rk?	scribe how injury occurred	
sio	Attanding or death. actor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	Yes 2 No	cation (Street and Number or Ru	un I Davida Alvenha e
<u>></u>	or At fler o Dirac in by	E	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		y or Town, State)	rai noble Ivalliber,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Ce	One Continue of Continue Physician T- the best of substantial death	me data and class and dis-	a to the enurge(s) and many	stated
	Hosi 24 ho Funs Funs tely f	Medical	29a. Certifler (Check only one) Check only one) Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated.	me, date and place, and due opinion, death occurred at th	e time, date and place, and due	to the cause(s)
	To tha within 2 To tha complet	Wed	one) and manner stated. 29b. Signature and title of certifier 29c. Licens	se number	29d. Date signed (Monti	h, Dav, Year)
	5 × 0 0		A A			_
	1.51			21809	July 24,	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-	MAN TO	-6. 5
			31. Date filed (Month, Day, Year) 32. Registrar's Signature,	TIMONIU	M MD 210	13
	St Regist	ate	how 4 hours			
	negişi	ावा	May 2 7 2004. Depart to process			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 22 ieber 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death OCH RAVEN CENTER PARKVILL TIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 D F 218-38-4789 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No BALTIMORE MARYLAND PARKVILLE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? MENOOD AVE NUE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ATHERINE EIRMANN WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EDGENCOD AVE, PARKVILLE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 Removal from State PARKVILLE, MD 27-04 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 21. Signature of Funeral Service Licenses 8800 HARRORD RD, PARKVILLE, MD 2123-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-aflure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mull disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 No Other: 1 🗌 Yes

Physician /Medical

Physician

/Medical

Examiner

Director

þ

Completed

Funeral

Director

If item 27 is marked other than "natural", or items 23s or 28s-f show or other treumstic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or any injury or other treumatic event, the Wedical Event retinual ban once.

Baltimore, Maryland 21215-0036

Examiner

Examiner Physician/Medical þ Completed

requires that the death certificate be executed

Hospital or Attending Physicien:

within 24 hours a To the Funerel D

Division of Vital Records, P.O. Box 68760,

tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Certification: To after death Director:

23h. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

6 Could not be determined

Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 - Homicide

29c. License number

29d. Date signed (Month, Day, Year) 23

30. Name and address of person who completed of death (Item 23a) (Type, Print) MD 212

and manner stated.

State Registrar

10

Medical

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

			State of Maryla	•	te of Death		Reg. No.2 11 11 1	001270
			Decedent's Name (First, Middle, Last)			2. Dete of Dee	oth C- U-	3: Time of Death
J.	Physicia		James William Norvell, Sr.			July	Dey Yea 22, 200	
	/Medic Examin		4e Fecility Neme (If not institution, give street end number)		4b. City, Town, or			
-	Lxaiiiii	CI	1200 Archia Count		Be1camp		Uax	eford.
_	Funeral		1300 Arabis Court 5. Sociel Security Number 6. Sex 7. Age (In yrs		r 1 Year If Under 24 Hrs		h 9. B	CFOrd irthplace (State or Foreign Country)
	Director		215-56-6728	. Yrs. Months	Days Hours Min.			Maryland
	Jend 1			ity, Town or Location				10d. Inside City Limits
	Manyler f show	ě	Maryland Harford	Belcamp				1 ☐ Yes 2 ☐ No
	28e	Director	10e. Street end Number	10f. Zip	o Code		10g. Citizen of Whet 0	Country?
	3a o		1300 Arabis Court		21009		USA	
	deatl	Funeral	11. Maritel Status 12. Was Decedent Ever in	U,S. 13. Was Dece	dent of Hispenic Origin? (Socify Cuban, Mexican, Puer	pecify Yes or No-		nerican Indian,
21215-0020	d within 72 hours efter death with the Marylend piene. r than "natural", or frems 23s or 28s-f show the Madical Examiner must be notified at	<u>۾</u>	Armed Forces? 1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ Vivorced Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		city Cuban, Mexican, Puen 2	to Hican, etc.)	Black, Wr Specify:	White
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usua	al Occupation	rkina	16b. Kind of Busines	s/Industry
21	thin 7	Pe-	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT u	ork done during most of wo ise retired)	King		
		် ပ	1	Sales & Se	ervice Clerk			ly Company
nd	tal Hy d oth	Be (17. Father's Neme (First, Middle, Last)				Maiden Surname)	
χ	should be filed within and Mental Hygiene. a marked other than " umatic event, in Mo	ဥ	Harold Bertram Norvell		Doroth	y (UNK)	Byron	
Maryland	0 0 0 0		19e. Informent's Name/Relationship (Type, Print)		s (Street and Number or Ru			Zip Code)
	s 1 end if Health itam 27 i	- }	James William Norvell, Jr.	21 Semire	ole Court, Al me of other place)	pleton,	WI 5419	4
Baltimore,	or or or		Partie La Cromation Calloniova non Ciaro					
ţ	Demit. Pag Depertment mportant: I any injury o	1	4 ☐ Donation 5 ☐ Other (Specify)	Bel Air Memo	orial Grdns.	7-27-04	Bel Air,	Maryland
Bal	Depertm Depertm Importal any inju		21. Signature of Funeral Service Licensee	22. Name an MCCOL	nd Address of Fecility Mas Funeral I	Home, P.	Α.	
	40 2 % U	ľ	stiply letherch	1317	Cokesbury Ro	oad, Abii	ngdon, MD	21009
de,			23a. Part . Enter the disease, or complications that caused the des shock, or heart failure. List only one cause of each line.	ith. Do not enter the mod	de of dying, such as cardiad	or respiratory ar	rest,	Approximate Interval Between
1	Physician							Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	JABETES				204x.
	\$	7	Due to ((or as e consequence of):				
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~	rificete be executed ng physician end es the bunel-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to ((or es e consequence of):				1
68760,	sicia e bur	edicai	Cause (Disease or injury that initiated events	or as a consequence of):				+
68	ificet g phy es th	ᄝ	resulting in deeth) Last	or as a corresquence or).				
Box		\$	d					
	death e ette	흥	Part II. Other eignificant conditions contributing to death but not re	sulting in the underlying c	ause given in Part I.	23b. Did to	obacco use contribu	te to the cause of death?
P.0	requires thet the death ce seen signed by the ettendii hould be deteched for use	Physician/M				1'□ \	'es 2□ No 3□	Probably 4 Unknown
	gnex bed	by						
Records,	v require been si should I	8				24a. Was a		. Were autopsy findings available prior to
ည္မ	e law re has be ge 2 sh	De					2	completion of cause of death?
Œ.	The law ete has b page 2 s	Completed				1.TY	BE BUTTO	1 ☐ Yes 2 ☐ No
Vital	lclan: The	Be	25. Was case referred to medical examiner?			ath (Check only or	ne)	
of V	<u>∞</u> 5	၉	1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ DO	OA Other: 4 Nursing H	ome 5 Psid	ence 6 □Other (Sp	ecity)
ם	ng Ph fter th inerel	ä	27. Menner of Death 1V Neturel 5 □ Pending (Month, Dey Year)		28c. Injury at Work?	28d. Describe h	ow injury occurred	
<u>S</u>	Attanding or deeth. Botor: After by the fune	cati	2 ☐ Accident investigation	М	1 ☐ Yes 2 ☐ No			
Division	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At I building, etc. (Special Could not be determined 5 Section 19 Sectio	nome, farm, street, factory ify)	y, office	28f. Location (S City or Tow	treet and Number or F n, State)	łurel Route Number,
	urs e	ဦ						
	Hospital	edicai	29a. Certifier Certifying Physician: To the best of my kni (Check only one) Check only and manner steted.	ation end/or investigation	at the time, date end place , in my opinion, death occu	rred at the time, o	ause(s) and manner a late and place, and du	is stated. ie to the cause(s)
	7 5 7 0	ĕ ¥	29b. Signature epel title of certifier	290	c. License number	2	9d. Date signed (Mor	ith, Dey, Year)
	F 3 F 8		1 () where soo I	MOS	1/1non		7/23/01	ø
	13	-	30. Name end address of person who completed cause of death (Ite	m 23a) (Type Print)	ARCHAN	0A 501	DAMA.	1
	1 0		1208 (1111) CHVILLE RA	BELAIR	MD. 2101	11		
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrer's Sign		10. 1			
	Registra	100	WH 2. 7 2004	D pp	our			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #2 per phy 6833 / 127/04 tas Certificate of Death Reg. No. For State Registrar 2004 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Doris Elizabeth Overholt /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care Ruxton Towson Baltimore 8. Date of Birth (Month, Day, Year) JUL 19, 1916 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 214-38-8714 88 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nnen of Heath and Mental Hygiene.
and: It Item 27 le marked other then "natural", or Iteme 23e or 28a-f show thy or other traumatic event, the Madical Examinational the mallified at uny or other traumatic event, the Madical Examinational the mallified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 No Completed by Funeral Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 6338 Frederick Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Hardware Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be Emma Stuhr Charles Rohrbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5127 Farnsworth Place Baltimore, MD 21206 Betty Bogert/sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or 7/24/04 Baltimore, MD 4 □Donation 5 □ Other (Specify) F. McBonald ²²MacNabb Funeral Home, P.A. 21. Signature of F 301 Frederick Road Catonsville, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 Schemic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) detached 9 Unknown 9 Unknown ፩ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Whenown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Horsing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 40 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 10 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Alter t Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deatl To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #209 11 monium, MA 21093 Asadi OE. limonium rd. rus 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar nun 27 2004

			State Registrar Decedent's Name (First, Middle,	Last)	(Certificate of	f Death	2. Date of De	Reg. No. U 4	2358
	Physic		Edna	Marva	O'Conn	ar.		Month	Day Yea	
	/Medi Examii		4a. Facility Name (If not institution,				or Location of Death	Jury '	23, 2004 4c. County of D	eath
			3618 Littledale	Road		Kensi	Ington		Montgo	
	Funeral Director				ge (In yrs. last birthe 89 Yr	(ay) If Under 1 Yea	r If Under 24 Hrs.	8. Date of Birt (Month, Da Aug. 1,	h y, Year) 9. I	Birthplace (State or Foreigr Country) aryland
	aryland show		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Mary Fresh	tor	MD Montg	omerv	Kens	ington				1 ☐ Yes 2 📉 No
	with the Maryland a or 28a-f show	Director	10e. Street and Number	<u></u>	TO THE	10f. Zip Code			10g. Citizen of What	Country?
	₽ 23	alD	3618 Littledale	Road Apt.	306	208	895		USA	
	ë E E	Funeral	11. Marital Status	12. Was Deceden Armed Forces	Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-		merican Indian,
0000-017	ours aff	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced		No	1 ☐ Yes 2 💢 N		Thous, Go.,	Specify: V	
ה ה	na na	Completed	15. Decedent' (Specify only highest	Education grade completed)	16a. D	ecedent's Usual Occi	upation e during most of work ed)	ing	16b. Kind of Busine	ss/Industry
717	within ene. than "	E E	Elementary/Secondary (0-12)	College (1-4or	5+)					
	e filed al Hygie other vent, II		12 17. Father's Name (First, Middle, L	N/A_ast)	E	xecutive	Assist	Giret Middle	Televisio	on Station
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2	2 should be and Mental Is marked raumatic ev	ြ	19a. Informant's Name/Relationsh		19b. N	ailing Address (Stree	et and Number or Rura	F. Ethe		Zin Code)
2	nd 2		Maureen D. O'Con				Manor Ct.			
5	es 1 and 2 of Health of item 27 I r other tra		20a. Method of Disposition		20h Place of D	enocition (Mama of			20c. Location - City	
	t. Partmer		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L	ecify)	Dulaney Memoria	Valley L Gardens	200		Timonium	ı, MD
ב ב	permi Depa Impo any Ir		Bujan	Bryan W. C	Ialy	IU W. Pado	neral Ĥome onia Road	Timoni	um. MD 210	y, Inc. 193
	/Medical Examiner	aminer	23a. Part1. Enter the disease, or of shock, or healt tailure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, begins to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	or Cinova a consequence of: a consequence of: a consequence of: 2 for	1 to 01	colon eng.			Interval Between Onset and Death
,00,00	rtificate be executed ng physician and as the burial-transit	cal Ex	resulting in death) Last	Due to (or as	a consequence of):	nous	Mounda	उत्त बी	ler.	
5		Medi			- 14			U)	
.0.	The law requires that the death cerate has been signed by the attending page 2 should be detached for use	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ⊟Ectopic pregnand 5 □ Other (specify)	су		23d. Date of d Month	lelivery Day Year
555000	quires that an signed b uld be deta	by	Part II. Other significant condition		out not resulting in th	e underlying cause g	ven in Part I.	23e. Did to	* /	to the cause of death?
	aw requir s been si 2 should	Completed	typeste	mia.				24a. Was a	ın 24b. Were	autopsy findings available
	The lav	E O						autops	med? prior to med? death?	completion of cause of
		BeC	25. Was case referred to medical				26. Place of Death			es 2 No
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	anding Physician: ath. or: After this certific ne funeral director,		27. Manner of D ath 1 Natural 5 □ Pending 2 □ Accident investiga		ury 28b. Tim iy Year) Inju	of 28c. Inju	iry at 2 ork?] Yes 2 □ No		ow injury occurred	
	s after de	Certification:	3 Suicide 6 Could no determin	ed 286. Place of In	jury - At home, farm, ic. <i>(Specify)</i>	street, factory, office	2	28f. Location (St City or Town	treet and Number or f n, State)	Rural Route Number,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) Certifying Check only one)	Physician: To the best caminer: On the basis of and manner st	it examination and/o	eath occurred at the t investigation, in my	ime, date and place, a opinion, death occurre	and due to the ca	ause(s) and manner a ate and place, and di	as stated. ue to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifie	eld	Mo	29c. Licen	se number, 91	2	9d. Date signed (Mor	6. 2004
	4		30. Name and address of person w	no completed cause of o	death (Item 23a) (Tvi	e, Print)	- ()		7/	1
	V				emocracy		thesda, MD	20817		
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature 🧳	1	-	2VUI/		
	Registr	ar	.101 2 7 20	104 Since	se B	Sparks	/			

		For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H <i>rtificate of I</i>			giene Reg. N2. 0 10 L	23582
		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea		3. Time of Death
Physicia /Medica		ALICE	PEARL	OLIVER			JULY	23 26	ar 6:10 P.M
Examine		4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Deat	1	4c. County of D	eath
		SAINT AGNES + 5. Social Security Number 6. Se	TEALTH C	ARE (In yrs. last birthday)	BGLTY If Under 1 Year	NORE If Under 24 Hrs.	8. Date of Birt	N/A	P. 1. (0
Funeral Director			″ м Ж Хг /	85 Yrs.	Months Days	Hours Min.	Month, Day	y, Year)	Birthplace <i>(Stat</i> e o <i>r Foreig</i> Country) VIRGINIA
		Usual Residence of Decedent		10. Oh. T.					
shov	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limit
28e-f show	Funeral Director		/A	BA	LTIMORE				
23a or 2 usi be n	吉	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
s 234	ral	1428 KINGSWA		51-1-110		1218		U.S.A.	and a last
Item	n.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🛣	ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	o Rican, etc.)	Black, W	merican Indian, Inite, etc.
if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f shov other treumatic event. Ite Medical Examinar must be notified at	by F	3 Midowed 4 Divorced	If Yes, Give Year or Dates:	40	1☐ Yes 2፟ No	Specify:		Specify: B	LACK
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- H	Completed	(Specify only highest grad	de completed)	(Give	kind of work done of DO NOT use retired	during most of word)	king		,
than than	E O	Elementary/Secondary (0-12) 9th grade	College (1-4or 5	'	MESTIC			PRIVAT	E
nd Mental Hygiene. marked other than imatic event. Its Mr	Bec	17. Father's Name (First, Middle, Last)		,		18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
Mental arked o atic eve	To B	LINNIE FLIPPEN				ANNI	E B. STR	EET	
le mai		19a. Informant's Name/Relationship (7	уре, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, Stat	e, Zip Code)
alth a 27 lc or tre	-	Avis Ransom/Niec	e	142	8 Kingswa	v Rd., B	altimore	, Marylan	d 21218
of Health of Item 27 I	-	20a. Method of Disposition		20b. Place of Dispe			Date	20c. Location - City	
	i	1 Burial 2 Cremation 3 `4 Donation 5 Other (Specify			ILY CEMET	1	29-04	Burkville	, Virginia
Department o Importent: If any injury or once.	İ	21. Signature of Funeral 3 vu Naicen	Vioren .	2	2. Name and Addres	ss of Facility		FUNERAL H	
		23a. Part 1 Enter the disease, or comp	olications that caused						Approximate Interval Between
Medical and pural-transit state burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Sicy- Due to (or as	a consequence of): a consequence of): LIPIDE a consequence of): ARY A	SYNOR MIA ETERY	DISEK	27 (Q)V		the year
20 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
signed b	þ	Part II. Other significant conditions co	ontributing to death be	ut not resulting in the u	inderlying cause give	en in Part I.	23e. Did to		e to the cause of death? Probably 4 □Unknow
plnods	eted	CARCERON	1-Cuni	PIOU	1101		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	63 22110 5	
ate has page 2	Completed				_		24a. Was a autop perfor	sy prior med? death	autopsy findings available to completion of cause of 1? 'es 2 \(\text{\text{\text{No}}}\)
- 5 - 5	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or	ne)	
S TO	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Unpatie	nt 2 ☐ ER/Outpatie	nt 3 DOA Othe	er: 4 🗌 Nursing H	ome 5 🗆 Resid	lence 6 Other (S	(pecify)
After to		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	y Year) 28b. Time o	Worl	yat k? Yes 2 □ No	28d. Describe h	ow injury occurred	
within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home, farm, st c. (Specify)			28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,
24 hours a Funere stely fille	Medical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ysician: To the best liner: On the basis of and manner sta	of my knowledge, deat examination and/or in ated.	h occurred at the time vestigation, in my of	ne, date and place pinion, death occu	, and due to the or rred at the time, o	cause(s) and manner date and place, and c	as stated. due to the cause(s)
o th	Me	29b. Signature and title of certifier	- Marina	<u> </u>	29c. License	e number		29d. Date signed (Mo	onth, Day, Year)
≥ <u> </u>		Granttun's	appen yell) ENDING CARDI	ma	Mag ILL	D0041711	TIM1 20	2 20071
≥ ⊢ 8				C. PALLETANNAL COM. F. L. B. C. C. L.	310/50 8 1 16/1	-U F @ T U - I	DIRTH HILL	1 1111 1 /	- / / · · · · · · · · · · · · · · · · ·
¥ <u>-</u> 8	ì	30. Name and address of person who o			Print)	YMIND	0011111	sort -	1 2201
≱ F 8		30. Name and address of person who of		eath (Item 23a) (Type,	Print)	NE CHIO	NUE SIL	200 PA	mere, may und 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 5: 30 PM LARRY RICE **Physician** UL 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford 305 Burnside Ct Joppatowne 8. Date of Birth 9. Bi (Month, Day, Year) 9. Bi Feb. 10, 1942 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Funeral 10XM 2□F 62 218-36-4520 Yrs. Director Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene the fire of terms 23e or 28e-f show item 27 fe marked other than "nature!, or terms 23e or 28e-f show other traumatic event, the Medical Examinant in transition of the contraction arford Joppatown 1 ☐ Yes 2 XNo Md. Director 10g. Citizen of What Country? 10f Zin Code 10e Street and Number 305 Burnside Ct. 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Machanic College (1-4or 5+) Maintenance 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerald Price Margaretta Marie Sommer 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Burnside Ct. Baltimore Md. Winifred Price / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Bayview Crematory * 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fulleral Service Lice 22. Name and Address of Facility Connelly funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** letastatic senal cell carcinomo 3months /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Nes 2 No 3 Probably 4 Unknown sem Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 **X**No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No 5 Residence 6 □Other (Specify) ٩ 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide

Examiner attending physician and for use as the burial-transit death certificate be executed P.O. Box 68760 the ģ been signed be should be detailed Division of Vital Records, has certificate this neral Director: After the filled in by the funeral or Attending death. after To the Hospitel within 24 hours a To the Funeral D

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

completely 4

Medical

602, S. ATWOOD ROAD, SUITE 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

29a. Certifier



esaelan M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BELAIR MD 21011

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D45530

29d. Date signed (Month, Day, Year)

07-27-2004

	Plea	se Type or	Print in	Black	Indel	ible ink	Ene	ure A	II Conie	e Ar	Logih	alo.	
	1 100		f Marylaı									ne.	
1 - For State Registrer		Olaic o	i waiyiai			cate of			nemai i i		200	Į	00001
1. Decedent's Name	e (First, Middle	e. Last)			3071,771	0410 07	Doan	-	2. Date of D	Reg. I	10.	4	3. Time of Death
		nt P. Po	tta						Month			Year	
		n, give street and nui			4b	City, Town, o	s Longtin-	-4 D4h	July	_ 25			7:05 P M
		Center	nosi)		40.			or Death		1	c. County o		•
5. Social Security N		6. Sex	7. Age (In yrs.	last hirth	day) If (Towson		r 24 Hrs.	8. Date of B	indle			imore
218-24-21		1 ☐ M 2 💢 F	_	77 Y	Moi	nths Days	Hours	Min.	(Month, D	$\stackrel{\scriptscriptstyle(ay)}{\downarrow}\stackrel{\scriptscriptstyle(y)}{\downarrow}\stackrel{\scriptscriptstyle(y)}{\downarrow}$	927	Cour	place (State or Foreign http:/ inois
Usual Residence of	f Decedent									, _	<i></i>		1110110
10a. State	10b. County		10c. C	ity, Town	or Location	1						1	10d. Inside City Limits
Maryland	Howa	rd	E	Ellic	ott (City							1 ☐ Yes 2 No
10e. Street and Nur	mber				10	f. Zip Code				10g. C	itizen of W	hat Cour	ntry?
4240 S	Scarlet	Sage Cou	rt			2104	42				USA		
11. Marital Status1 ☐ Never Marri3 ☐ Widowed		Armed Fo	2X No	J.S.	If Yes,	Decedent of H specify Cuba es 20 No	lispanic Or an, Mexica Specify	in, Puerto	ecify Yes or N Rican, etc.)	0-		, White,	
(Spec	15. Decedent	t's Education st grade completed)	-	(6	Give kind o	Usual Occup	during mo:	st of work	ing	16b.	Kind of Bus	iness/Ind	dustry
Elementary/Seco	indary (0-12)	College (1	-4or 5+)		ditor	OT use retired	1)			Dep	oartme	ent i	Store
17. Father's Name	(First, Middle,	Last)					18. Moth	er's Name	e (First, Middle	, Maide	n Sumame,)	
C. C	Donel	1 Pascaul	-				T.	vdia	Rouse				
19a. Informant's Na				19b. N	failing Add	dress (Street			Al Route Numb	er. City	or Town. Si	tate. Zin	Code)
Conrad	Gordon	/ Son				arlet							
20a. Method of Disp		, 5011	20b. I	Place of D	isposition	(Name of			Date		ocation - C		MD 21042
1 ☐ Burial 2X	Cremation	3 ☐Removal from	STATE			or other plac Ory In	· .	7/27	7/0/.			•	
21. Signature of Fu		Licensee			22. Nam	e and Addres	ss of Facili	ity			timor Inc.		1 21228
23a. Part1. Enter th	ne disease, or	complications that ca	aused the deal	h. Do not	enter the	mode of dyin	g, such as	cardiac o	r respiratory a	ore,	Mary	Lanc	Approximate
Immediate Cause (disease or condition	Final	only one cause on e	ach line.	Can	cer				, ,				Interval Between Onset and Death
resulting in death)		a. Due to (or as a coosed		:								Jean
													0
Sequentially list conditions, Tany leading to immediate cause. Enter Underlying Cause (Disease or injury) Disease or injury													
that initiated events resulting in death) L		c. Due to (or as a conseq	uence of):									

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Iteme 23a or 28a-f show any injury or other treumetic event, Ira Madical Examinat invest be retilified at once.

To Be Completed by Funeral Director

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

al Examiner	Sequentially list corcause. Enter Under Cause (Disease or i that initiated events resulting in death) L	riediata rlying njury
ification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 the past 12 the past 12 the past 12 the past 12 the past 12 the past 11. Other significant in the past 11. Other significant in the past 11. Other significant in the past 11. Other significant in the past 11. Other significant in the past 11. Other significant in the past 12 the past	nonths? No
ification; To Be Cor	25. Was case referrence warminer? 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	

Medical Cert

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence d.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 No 9 \(\text{Unknown} \) Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 ☐ Ectopic pregnancy	
5 Other (specify)	

23d. Date of delivery Month

nber,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part

Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou

28a. Date of Injury (Month, Day Year)

200: Did lobacco di	30 001	itioute to the cac	ise of death:
1 □ Yes 2	No	3 Probably	4 DUnknown
24a. Was an autopsy performed?	24b.	Were autopsy fir prior to completideath?	ndings available on of cause of

	1 ☐ Yes 2 X N	10	1 🗆 Yes	2[
eath (C	heck only one)			
Home	5 Residence	6 🗶	Other (Speci	fy)
28d.	Describe how inj	ury oc	curred	

			26	B. Place of De	ath (Ci	heck only one)		
tpatient	3 🗌	DOA	Other:	4 🗌 Nursing	Home	5 Residence	6 Other (Specify)	
ime of njury		28c.	Injury at Work?		28d.	Describe how inju	ury occurred	
	М		1 🗆 Yes	2 🗆 No				

5 Pending investigation	(Month, Day Year) 280. Inme of 28c. Injury at Work? Injury M 1 □ Yes 2 □ No	28d. Describe how injury occurred
6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Num City or Town, State)
Certifying Physi	cien: To the best of my knowledge, death occurred at the time, date and pla-	ce, and due to the cause(s) and manner as stated

29a. Certifier (Check only one)	Certifying Physic Medical Examine	cien: To the best of my er: On the basis of exa- and manner stated.	knowledge, death occ mination and/or investi	urred at the time, date and place, a gation, in my opinion, death occurre	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
29b. Signature and	title of certifier	10	1210	29c. License number	29d. Date signed (Month, Day, Year)

	VI	1. Stath	my/lile) 0	17300	7	700	706	,000
30. Name	and add	iress of person who	completed cause of de	th (Item 23a) (Type,		2 11		7	-
141	7.1	Kilora	LIDMC	1701 1	(Charles It.	Mal sto.	ma	210	10)0

State Registrar

31. Date filed (Month, Day, Year) JUL 2 7 2004

32. Registrar's Signature oaks

28b.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Dav **Physician** 2004 26, Carl Post 9:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1002 Wilmington Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Months Days Hours Yrs. Director West <u>Virginia</u> 717-34-8862 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits in than "natural", or Itams 23e or 28e-f show the Medical Exercit personal be notified at 1 XYes 2 □ No Directo Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 1002 Wilmington Avenue USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Seafood Market 10 Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fand Mental Glenn Post Oleta Pringle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerri Jones/Daughter 720 Penny Court Pasadena, MD 21122 s 1 and 2 of Health itam 27 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Importent: If its Pages nent of t 8/1/04 Copen Cemetery A □ Donation 5 □ Other (Specify) Copen, WV 21. Signature of Funeral Service Chansee
Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Cátonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small Physician VON 6 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the t IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) o. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 X Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has 1 ☐ Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 🗌 Yes 2 No P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Ihis funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: the 3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 900 AGNES CATON AVE COLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 7:00 AM ayne 2004 4a. Fecility Name (If not Institution, give street and number) BALT more July /Medical Examiner 4b. City, Town, or Location of Death 4c. County of Deeth Rehab Extended CARE CENTER BALTIMORE NIA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months **X** 2 ☐ F Director 60 219-40-0743 23 05 44 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location or than "natural", or Items 23a or 28e-f ahow If a Mudical Examiner must be notified at 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3712 Ferndale IJ.S.A. 14. Race - American Indian, Ave 21207 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No ģ Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Itam 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Laborer Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Payne Yvonne L. Howard 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other trai Yvonne Payne-Mother 4316 Hayward Ave, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 urial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 7/29/04 Owings Mills, Md 21. Igrature of Faneral Seprice Lifensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician anaveatic ON CRY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed iding physician and ise as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: use If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No funeral director, 25. Was case referred to medical 26. Place of Death | Check only one examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 patient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury within 24 hours after death. To the Funeral Director: A М 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) ro the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D41365 July 24, 2004 IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Boulevard, Battimore, MD. 21218 3900 20:19e 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15 P M Day Year Jung Park **Physician** 2004 July /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death County of Death Examiner Howard County General Hospital columbia toward If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 1 X M 2 □ F 215-11-2790 16, 1927 Korea June Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count 10a. State 28a-f ehow r than "natural", or Items 23a or 28a-f ehov the Madical Examinar must be notified at Severn 1 ☐ Yes 2X No Anne Arundel Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21144 8364 Flintlock Court 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. ifiled within 72 hours after I Hygiene. other than "natural", or Ite 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Asian 3altimore, Maryland 21215-0036 1 ☐ Yes 25tNo Specify: Specify: à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BGE Administration permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event, Iffa ance. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Soon Yi Song Teuk Kun Park 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellicott City, MD 21042 3185-302 Pine Orchard Lane Jong Kim - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Removal from State i 7/28/04 Elkridge, Maryland Meadowridge Mem. Pk. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gary I. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 Mah 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Accident Immediate Cause (Final disease or condition resulting in death) 4 years erebral Vascular Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached f 9 Unknown To the Hospitel or Attending Physician: The law requires that the vaithin 24 hours after death. Within 24 hours after death. To the Funerel Director: After this certificate has been signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed Dulmonary diseas Chronic obstructive 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ဥ After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier miD. D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, MD 21844 5755 Cedar Lane, Harry 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

			1 - State Registrar	te of Maryland / Depa <i>Cer</i>	artment of Health and tificate of Death	Mental Hygier	2001. 22500
1	Physic		1. Decedent's Name (First, Middle, Last) Robert K. Parks			2. Date of Death	Day Year 10:50 PM
	/Medi Examir		4a. Fecility Name (If not institution, give street a Union Memorial Hospi		4b. City, Town, or Location of Dear Baltimore		4c. County of Death N/A
No.	Funeral Director		5. Sociel Security Number 216–42–5187 6. Sex 152 M 25 Usual Residence of Decedent	7. Age (In yrs. last birthday) F 58 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Yea	9. Birthplece (State or Foreign Country) 1945 Maryland
	death with the Maryland ms 23a or 28a-f show	tor	Maryland N/A	10c. City, Town or Lo. Balt	cation imore		10d. Inside City Limits %\%\\ZYes 2 □ No
	th with the 23a or 28s	ai Director	10e. Street and Number 850 W. 36th Street		10f. Zip Code 21211	10g. (Citizen of What Country? USA
980	iges 1 and 2 should be filed within 72 hours after death with the Marylar of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if a Medical Examinar must be notified.	by Funeral	1 Never Married 2 Married 1 If Y	Yes 2 No	Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Coll	lege (1-4or 5+) (Give I life. D	ent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16b.	Kind of Business/Industry
70	uld be filed within Aental Hygiene. rked other than ' ttc event, tre Me	To Be Co	17. Father's Name (First, Middle, Last) Gordon Parks	Snee	trock Hanger 18. Mother's Nai Frances	me (First, Middle, Maide Lomeyer	Construction en Sumame)
_	and 2 should be eatth and Mental in 27 is marked one traumatic ever		19a. Informant's Name/Relationship (Type, Prin Grace Parks Wii	19b. Mailing	Address (Street and Number or Ru N. 36th Street I	ural Route Number, City Baltimore,	y or <i>Town, State, Zip Code</i>) Maryland 21211
Baltimore,	t. Pa rtmer rtant: rjury		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Grema	atory or other place) -Washington atory		Location - City or Town, State ure1, Maryland
Ba	Depariment of the poor of the		21. Signatur Vof Pineral Service Licens	euss Bur	Name and Address of Facility cgee-Henss-Seirz 31 Falls Road, Ba	1timoro M	aryland
	Physician /Medical		23a. Pert1. Enfer the disease, or complications shock, ortheart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a on each line.	y Distres	Solitespiratory arrest,	Approximate Interval Between Onset and Death
,00	Examiner hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of):	liver dis	euse_	1 year
x 68760,	ertificate be e. ding physician e as the buria	Medical	d	Alconol	asuse		30 years
O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P.	w requires that been signed be should be det	ρχ	Pan II. Other significant conditions contributing Hyperten Ston	g to death but not resulting in the und			use contribute to the cause of death?
		e Completed	OF Was associated to a second			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \$\sumeq\$ Yes 2 \$\sumeq\$ No
	hys this	ToB	1 Actural 5 Pending 2 Accident investigation	npatient 2 ER/Outpatient Dete of Injury (Month, Day Year) 28b. Time of Injury	Other	th (Check only one) ome 5 Residence 28d. Describe how inju	
Divis	Hospital or Attendii 4 hours after death, Funeral Director: A tely filled in by the fu		4 Homicide	Place of Injury - At home, farm, stree building, etc. (Specify)		City or Town, Stat	
	To the Hospital o within 24 hours at To the Funeral D completely filled in	Medical	one) and	o the best of my knowledge, death of the basis of examination and/or inve manner stated.	occurred at the time, date and place, stigation, in my opinion, death occur	and due to the cause(s red at the time, date an	s) and manner as stated. id place, and due to the cause(s)
	So Twit	2	29b. Signature and title of certifier	am.	29c. License number AT 24389		ate signed (Month, Day, Year)
	, 4		30. Name and address of person who completed	cause of death (Item 23a) (Type, Pi	rint)		Timerell language and
3/4	Stat Registra	~	31. Date filed (Month, Day, Year) JUL 2 7 2004	33. Registrar's Signature	back	many took	The standard and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Of Day 25 Month M9 OF: [Anna I. Russell 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bel Air Mariner Health of If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 18, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days Hours 1 □ M 2 F Months 90 Maryland 214-64-9299 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 1 ☐ Yes 2 No Completed by Funeral Director Harford Bel Air Maryland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21014 USA 410 Fast McPhail 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) N/A UNK. Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK. Anna Thomas A. Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 412 Poole Road, Apt. C2 Westminster, MD 21157 Veronica Ganjon/Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 7/26/04 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature i Euneral Service Consee Fdward A. Gregorchik Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death luborasi Immediate Cause (Final 4 eel disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 🗖 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Mursing Home 5 Residence 6 ☐Other (Specify) 1 Tes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

Hygiene. other then "natural", or kems 23a or 28a-f show ent, the Matdical Exeminar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death a Depertment of Heelth and Mental Hygiene. Important: If Item 27 ie markad other then "natural", or Items 23a eny injury or other treumatic event.

Baltimore, Maryland 21215-0036

this certificate has been signed by the ettanding physicien end ral director, pege 2 should be detached for use as the burial-transit Box 68760 P.O. I or Attending Physician: After Director:

Physician/Medical þ Completed

Certification; To 27. Manner of Death

cal

1 Natural 2 Accident

3 Suicide

29a. Certifier

29b. Signature

4 Homicide

(Check only one)

5 Pending

investigation

6 Could not be

State Registrar

31. Date liled (Month, Day, Year) JUL **2 7** 2004

30. Name and address of person

01 32. Registrar's Signature

no completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Parminer: On the Dasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

ORIGINAL

28b. Time of

28e. Place of Injury - Al home, larm, street, lactory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

within 24 hours after To the Funeral Dire

ů,

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Day 2004 Sear 23, **Physician** 2:42P M Forbes T. Roseth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Towson Gilchrist Center 8. Date of Birth (Month Day, Year) NOV 18, 1911 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**∑**M 2□F 92 Yrs. 473-10-6227 North Dakota Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ns 23a or 28e-f show 1X Yes 2 □ No Baltimore N/ADirector Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 USA 3900 N. Charles Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Specify: White ō 1 ☐ Yes 2 X No Specify: ò 3 ₩idowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Copy Machine Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Frisk Cornwallis Roseth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 943 Rancho Santa Fe, CA 92067 Jeri R. Schwartz-Smith,daughter item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 7/24/04 ō Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 19 M /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Cther (specify) 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy perform Yes 2 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner's Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Other (Specify) CSP! CO 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence Certification: To After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

of Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral C

completely filled

Baltimore, Maryland 21215-0036

State Registrar

5

31. Date filed (Month, Day, Year) JUL 2 7 2004

(Check only one)

29b. Signature and title of certifier

Charles MD 600

and manner stated

8303

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles ST Baltmore MD 21204

82. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 59 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** C3:10 2004 JULY 25 Μ. Ripken Ruth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE SAMARITAN G000 Under 1 Year | If Under 24 Hrs onths | Days | Hours | Min. 8. Date of Birth (Month, Day, Ye May 04, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 25 F 1920 84 Maryland 215-16-9173 Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b County 28e-f show the Medical Examiner must be notified at 1 XYes 2 No Director Md. N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 5719 Edgepark Road 21239 USA 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Importent: If Item 27 is marked othe any Injury or other the contract of the contrac 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Alderson Manlove John 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2810 Glen Elyn Way Baldwin, Md. 21013 Mrs. Cheryl Dougherty/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 7-28-04 Woodlawn, Md 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Lig 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) INTRA CEREBRAL HEMORRHAGE /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner iding physicien and ise as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 menths? 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown 9 🔲 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 20 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes Division of Vital o the Hospital or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 npatient 2 ER/Outpatient 3 DOA ٩ 1 🗌 Yes After thi Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred Certification; 1 Natural 1 Yes 2 No investigation within 24 hours after deam.

To the Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JULY 000 Kazve 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 RAVEN 5601 LIXH BALTIMORE , 6000 HOSPITAL IZUKANJI SIKAZWE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 7 2004 Registrar

			- State AMEND ITEM #1	State of Maryland 7 PER FH C833	/ Depa	artment of H	lealth and Death	Reg.		00000
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) ALBERT C.	RUBY				2. Date of Death Month 2	3 2004	3. Time of Death 13.15 p M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	ath U	4c. County of Dea	
			NORTHWEST HOSPITA		ne birebala ul	RANDALLS If Under 1 Year	TOWN If Under 24 Hr	S R Data of Righ	BALTIMO	RE thplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sec. 219-10-1055	7. Age (III y/s. la	Yrs.	Months Days	Hours Mir		ar) C	MD
		ŀ	Usual Residence of Decedent	00				12/10/1925	,	
	yland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	a Ma la-fa	cto	MD BALTIMOR	E PIKES	VILLE					1 ☐ Yes 2 No
	ith th	Dire	10e. Street and Number			10f. Zip Code			Citizen of What Co	ountry?
	death with tha Maryland ims 23a or 28a-f ahow r inuat be notified at	rai	3800 OLD COURT ROA		12.1	21208	innania Origin?		S.A.	occan Indian
8	filed within 72 hours after death with the Marylar Hygiene. Hysiene. Hygiene "naturat", or itams 23a or 28a-1 ahow ant, the Macigal Examinar must be notified at	y Funerai Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWI]		Mas Decedent of H f Yes, specify Cuba l ☐ Yes 2 % ,No	Specify:	Specify Yes or No- into Rican, etc.)	Black, Whi	te, etc.
2-003p	hour:	ed by	3 XWidowed 4 ☐ Divorced 15. Decedent's Edu			ient's Usual Occup	ation	166	. Kind of Business	/HITE
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פ	e filac tl Hyg otha vant,	Φ	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, Maid	den Sumame)	
Maryland	nould by Mentanarkad	To B	CHARLES A F	RUBY	RUDY		FRANCES			HUPKA
a D	12 shoul h and Me 7 is marl traumati		19a. Informant's Name/Relationship (Ty					Rural Route Number, Ci		Zip Code)
	s 1 and f Health itam 27 othar tr			GHTER	ce of Dieno	cition (Name of		LTIMORE, MD) 21207 . Location - City or	Town State
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Ball	permit. Pagi Department important; fi any injury o		21. Signature of Funeral Service Licens					OL LEVINSON ROAD - PIK		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death.					LJVILLE,	Approximate
	Dhusisian		tmmediate Cause (Final	ne cause on each line.	mal	anos	1M02	ing		Interval Between Onset and Death
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	ecuter ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
760,	ate ba executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	ence or):					
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9 X O	The law raquires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d. Date of de	livery
ñ	death a atter d for u	iclar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de]Ectopic pregnancy] Other (specify) _	/ 		Month	Day Year
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ecords,	e law ra has be je 2 sh	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
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<u>></u>	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certification of the funaral director, completely filled in by the funeral director.	erti	4 Homicide	building, etc. (Specify)			City or Town, S.	·	
	To the Hospital or within 24 hours afte To the Funarai Dir completely filled in	alc	29a. Certifier To Certifying Phy	ysicien: To the best of my know	vledge, deat	h occurred at the til	me, date and pla	ce, and due to the caus	e(s) and manner a	s stated.
	n 24 n 24 he Fu	edical	(Check only 2 Medical Exem	iner: On the basis of examinati and manner stated.	ion and/or in	vestigation, in my o	opinion, death oc	curred at the time, date	and place, and du	e to the cause(s)
	To tl withi To tl com	Σ	29b. Signature and Little of certifier	2011 010		29c. Licens	se number	29d.	Date signed (Mon	th, Day, Year)
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	10	1	0. Name and address of person who o	completed cause of death (Item	23a) (Type,	Print)	ret Hus	ruted Cast	e U	
		1	31. Date filed (Month, Day, Year)	PANGADA JA	ure	1.(01,0))		1004
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	/Medi		4a. Facility Name (If not institution, give	Street and number)	NON SHE	ARD JR. or Location of Deat	July 22,	2004	0149 A M
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	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last			8. Date of Birth	N. Bish	IA
	Director			M 2□F 29	Yrs. Months Day		Month, Day, Year	Sall Cou	
	P.		Usual Residence of Decedent				NO1.02,1	TITA	RYLAND
	show	_	10a. State 10b. County	10c. City, T	own or Location	BALTIMORE	1		10d. Inside City Limits
	Ba-fa	cto	MARILLAND SALT	IMORE	RAN	DALLST	own		1 Tyes 2 No
	er death with the Maryla Items 23a or 28a-1 sho	Funeral Director	10e. Street and Number	1 4 .	10f. Zip Code	•	10g. C	itizen of What Cou	ntry?
	ath w	rai	3411 WASH	INGTON AVE	NUE	2124	4	USA	
	items	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	can Indian.
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ♠ No If Yes, Give	1 ☐ Yes 2 🕱 N			Specify:	0.0.
5-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Exartinest be notified at	edt	15. Decedent's Edu	Year or Dates:	So. Donodentia Havel Con			132	ACK
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	Hygie other	Bec	17. Father's Name (First, Middle, Last)	7.0	~///- ~	18. Mother's Nam	ne (First, Middle, Maidei	Sumame)	COMPARY
lar		To B	RONALD 1	. SHEAR	D .SR.	GLOG	In	R-	^
Maryland	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	9b. Mailing Address (Stre	et and Number or Ru	ral Route Number, City.	Or Town State Zin	Codel
	C - N -		GLORIAT. REI	D (MOTHER)			AVE, BALT	IMORE, MD.	~ 21244
Baltimore,	es 1 and of Healt ritem 2 rother		20a. Method of Disposition	20b. Place	of Disposition (Name of etery, crematory or other p			ocation - City or To	own, State
E			1 ABurial 2 □ Cremation 3 □ F 14 □ Donation 5 □ Other (Specify)	dilloval from State	DON PARK (EMEUT-	18-14 12	- MORE	har a comment
alti			21. Signature of Funeral Service Licens			ress of Facility	CO O T XX	TIMORE	1 1
m									
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory artist, shock, or heart failure. List only one cause on each line.								Approximate
	Physician		Immediate Cause (Final disease or condition		ound to 4	ho back	of the ches	+	interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequent		Doort	7 10 2 01022	•	
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9 x		00 1	IF FEMALE:						
Вох	death certi e attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		су		23d. Date of delive	,
o.	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)			Month	Day Year
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of Vital Records,	90	Ω		and the document for the second	g in the underlying cause g	IVALLE (I. L. SILL).	23e. Did tobacco t	V	
Ö	w requir been si should I	etec					TE Yes 21	No 3 ☐ Proba	ably 4 Dunknown
360	a 2 C	Completed					24a. Was an autopsy	24b. Were autop	sy findings available
a	iclan: The certificate ha						performed? 1 Yes 2 ☐ No	death?	pletion of cause of
Ĭ.	Physiclan: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	ospital:			(Check only one)		
of	두 등 교	: To	1 X Yes 2 No ☐	1 Inpatient 2X ER/0	Dutpatient 3 DOA		me 5 Residence)
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S	or Attending ifter death. Director: After in by the fune	Ica	2 Accident investigation 3 Suicide 6 Could not be			Yes 2 X No	Subject		
Division	after after Dire	Certification;	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	Y		28f. Location (Street and City or Town, State)	Number of Rural	Route Number,
	spital ours nerai filled		29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my knowled	t home		Fruit time n	stary .	The second secon
	24 h 24 h 9 Fur etely	Medicai	(Check only 2 Medical Examin	ician: To the best of my knowled er: On the basis of examination a and manner stated.	ge, death occurred at the tand/or investigation, in my	ime, date and place, opinion, death occurr	and due to the cause(s) ed at the time, date and	and manner as sta place, and due to t	ted. the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier		29c. Licen			e signed (Month, D	
)	r s r ó			m, D		M.E.			
•		1	30. Name and address of person who cor			n.E.	July	22, 2004	4
	Q		LING LI.			Street P	altimore, M	[aver]	21201
	Sta	e	31. Date filed (Month, Day, Year)	32 Registrar's Signature			cicinote, M	car A Tarki	21201
	Registra	_	JUL 2 7 2004	Spever 1	9 Sporks	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State State C	of Maryland / Depa Ce	artment of He rtificate of D			iene	23501.
			Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
	Physici /Medio		Ghamar Sedaghat				July 1	Day Year 15, 2004	8:15₽ ^M
já.	Examir		4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, or L	ocation of Death		4c. County of Dea	
			Fort Washington Med			ashingt		Prince	Georges
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) Yrs.		Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign ountry)
	Director		578-98-3817 Usual Residence of Decedent	84			Mar. 1	1, 1920 _{T1}	urkminista
	yland Iow		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar Mar	ķ	MD Prince Georg	es Fort Wa	shington				1 ☐ Yes 2 No
	th the	Director	10e. Street and Number	<u> </u>	10f. Zip Code		10	0g. Citizen of What Co	ountry?
	23a		10808 Riverview Rd	•	20744			USA	
	tems	Funeral	Armed Fo	edent Ever in U.S. 13. orces?	Was Decedent of Hisp If Yes, specify Cuban,	oanic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	I within 72 hours after death with the Maryland jiene. rithen 'naturel', or Iteme 23a or 28a-f show Ite Medical Exercit et trust be metified at	by Fi	1 Never Married XXMarried 1 Yes If Yes, Gi Year or D	VA .	1 ☐ Yes 2€ No	Specify:		Specify: Wh	4.6.
21215-0036	hour		15. Decedent's Education		dent's Usual Occupation	on		16b. Kind of Business	
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212		E O	Elementary/Secondary (0-12) College (, I	ırse			Healt	h
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<u>la</u>	thould by the marked marked marked	10	Ali Sedaghat			Leghyie	eh Ejte	mai	
Maryland	S a a		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and				
	1 and 1 Health 16m 27		Esfandiar Aghdassi		5 Creek				
Baltimore,		11.3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from	Oldio	osition (Name of matory or other place)		ate 2	20c. Location - City or	Town, State
Ë	Pa ant: ury		`4 Donation 5 □ Other (Specify)		nfort Cem			Alexandr	
Bal	permit. Departr Importa any inj		21. Signature of Fureral Service Licensee	-//	2. Name and Address			2 Braddo	
			23a. Part1. Enter the disease, or complications that of		airfax M			rfax, VA	22032 Approximate
			shock, or heart failure. List only one cause on a	each line.	1		A .	,	Interval Between Onset and Death
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٥.	The law requires that the ste has been signed by th page 2 should be detache		Part II. Other significant conditions contributing to d	eath but not resulting in the u	inderlying cause given	in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	sign sign d be	d by	ATRIAL FIS	-illatin	, ,		1 ☐ Yes	s 2 No 3 Pr	robably 4 Anknown
00	w requir been si should	ompieted	Co. o 6 a 11 V	Decular.	Braid	Ou A-	24a. Was an	24h Wara a	utopsy findings available
Re	The law ate has page 2 s	щ	The state of	A Julio or	· v		autopsy	prior to death?	completion of cause of
		S	25. Was case referred to medical			26. Place of Death	1 Yes 2		2 No
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joi	Attending r death. sctor: After by the fune	atio	2 Accident investigation	in, bay roar, inquity		s 2 🗆 No			
Division	r Atte	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	of Injury - At home, farm, str ng, etc. (Specify)	reet, factory, office	2	28f. Location (Stre	eet and Number or Ru State)	ural Route Number,
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier Certifying Physician: To the Control (Check only 2 Medical Examiner: On the b	asis of examination and/or in	h occurred at the time, vestigation, in my opin	date and place, a	and due to the car	use(s) and manner as te and place, and due	stated. to the cause(s)
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	5		5 (1/1	se of death (Item 23a) (Type,	121 (C+ INIAC	thus also	(11) 2	20744
	Sta	te	31. Date filed (Month, Day, Year) 32. F	legistrar's Signature	/ Na. F	1. 1/1 00	MILATEL	1, 1411 E	0/17
	Registr	_	1111 2 7 2004 Sen	we By	park				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** UOLY 2004 ANIHON) WILLIAM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Elkridge Howard 8012 Paul Martin Drive Date of Birth (Month, Day, Yea AUG 24, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) **Funeral** Months Days 10 M 2□ F 1943 New York Yrs. 60 051-34-7659 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No **Elkridge** Directo Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 23a 21075 USA 8012 Paul Martin Drive Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐Yes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced White "netural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical College (1-4or 5+) Elementary/Secondary (0-12) other than Gov't. Construction Building Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be filt Deperment of Heelth and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event QDCs. Be Summa, Sr. Bernice Sierak William Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anthony J. Summa, brother 64 Melwood Drive Rochester, NY 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 07/27/04 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Cremation Society of MD, Inc. MacNabb, M00397 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Curhosi Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner dependency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours atter death. To the Funerel Director: A 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 | Homicide tilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D37777 July 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21045 Two Knoll North Dr. Columbia, MD M.D. Peter W. Cheng, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar IIII 2 7 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 30 1 200 (d 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (If not institution, give street and number) Baltanove N/ARESINELL MUMCENTE CENT 7. Age (In yrs. last birthday). If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 5, 1920 6. Sex 1 M 2 □ F Birthptace (State or Foreign Country) 5. Social Security Number Days Hours Virginia 218-07-5942 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ZYes 2 No Baltimore N/AMaryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 USA 3703 Clarenell Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Pace - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fabrication Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Pitts Arch Southworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 3703 Clarenell Road Baltimore, MD 21229 19a. Informant's Name/Relationship (Type, Print) Lois Southworth/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 7/23/04 Baltimore, MD Metro Crematory, Inc. 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 Thomas Gregor (Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) Nede dication Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnant Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28e-f show

Director

Funeral

ģ

Completed

item 27 is marked other than "natural", or items 23a or 28e-f shov other treumatic event, the Mudical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Item eny Injury or other treumatic event, the Medical Execut

Baltimore, Maryland 21215-0036

Examine signed by the attending physician and deetached for use as the burial-transit Physician/Medical 2 Completed Be Certification: To this After

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records.

or Attending Physicien:

To the Hospitel

death.

within 24 hours after death

To the Funeral Director:
completely filled in by the

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 20 No 9 Unknown

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office builting, etc. (Specify)

28b. Time of

Injury

a hruman

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

24a. Was an autopsy 2 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Unknown

Other: 4X1 ursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

fell from standing 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3103 Lanchell Da Palhune

1 ☐ Yes 2 ☐ No 3 ☐ Probably

curifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainten stated.

29b. Signalare and title of certifier

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical

2∏No

examiner?

27 Manner of Death

Natural

2 Accident
3 Suicide

4 | Homicide

(Check only

29a. Certifier

29c. License number 58303

1 Yes

29d. Date signed (Month, Day, Year) 200 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MU) horles

ST Baltimore UN 200 W. 40m 82. Registrar's Signatur

State Registrar

JUL 2 7 2004

31. Date filed (Month, Day, Year)

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F rtificate of			Reg. No.		23597
	Physicia /Medic		Decedent's Name (First, Middle, La.	Dorathe	ea V.	Seicke		2. Date of De Month July	22, 2	00 4	3. Time of Death 11:00 PM
	Examin Funeral		4a. Facility Name (If not institution, given St. Elizabeth 5. Social Security Number 6. S	Nursing lex _ 7. Age	Home (In yrs. last birthday)	Ba	Location of Death Itimore If Under 24 Hrs. Hours Min.	8. Date of Birt	h	N/A 9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	□м 26 г	87 Yrs.		110013	(Month, Da AUG 8,	1916	Ma	ryland Od. Inside City Limits
	he Marylan 28e-f show	ector	MD Balti 10e. Street and Number		10c. City, Town or L		sterstow		10g. Citizen of		1 ☐ Yes 2 No
	s 23a or	Funeral Director	353 Town Gree	en Way	vor in II S 13		21136			USA	
980	urs after de al', or item Examiner r	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	tispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Spec	ack, White,	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If marked other than "natural", or Items 23a or 28e-1 show other traumatic event, the Madical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	DO NOT use retired	during most of work d)	ing	16b. Kind of I		rvice
nd 21	be filed withi tal Hygiene. d other than event, Ire M	Be Col	12 17. Father's Name (First, Middle, Last,			Waitres	18. Mother's Name		Maiden Suma	vme)	
Maryland	2 should be and Mental Is marked aumatic ev	인	Martin 19a. Informant's Name/Relationship (rrath	ing Address (Street	Jenni			Chane n, State, Zip	
	s 1 and 2 of Health a item 27 ls other trai		Caroline J. Kna 20a. Method of Disposition		20b. Place of Dispe			Reis	sterst 20c. Location		
Baltimore,	Page nent o ant: If ary or		1 Marial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Service Documents) 21. Signature of Funeral Service Documents	y)	Meadowrid	lge Mem. I	Pk. 07/26			idge	, MD
Ba	permit. Departr Importe any inje		George E. 1 23a. Part1. Enter the disease, or com	lacNabb	3	01 Fred	funeral erick Ro	ad Cat	onsvi	11e,	MD 21228
0,	Physician /Medical Examiner but sthe prival-transit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Average on each line a. Due to (or as a c.	consequence of): consequence of): consequence of):	د را					Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certilicate be to has been signed by the attending physici bage 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o	Fetal death 3	□Ectopic pregnancy	у			ate of delive	ry Day Year
<u>α</u>	quires that I n signed by uld be deta		Part II. Other significant conditions of	/ . /	t not resulting in the u	underlying cause giv	ven in Part I.		obacco use con res 2 No		e cause of death? ably 4 Unknown
Vital Records,		Completed by								Were autoprior to condeath?	psy findings available inpletion of cause of
Vita	Physicien: The I rthis certificate har ral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	it 2 ER/Outpatie	ont 3 DOA Oth	26. Place of Death			ther (Specify	r)
ion of	ng Pr fter th ineral		27. Manner of Death 1 Natural 2 Accident S Pending investigation	28a. Date of Injury (Month, Day	28b. Time (of 28c. Injur		28d. Describe h			,
Division	al or Attendi s after death. Il Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, st (Specify)	treet, factory, office		28f. Location (5 City or Tov	Street and Num yn, State)	ber or Rura	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of miner: On the basis of a and manner stat	examination and/or in	th occurred at the tin nvestigation, in my o	me, date and place, opinion, death occuri	red at the time,	date and place	, and due to	the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	aink		29c. Licens	951		29d. Date sign	ed (Month, I	Oay, Year)
_	6		30 Name and address of person who	completed cause of de	ath (Item 23a) (Tape	Elduk!	00 Cotro	nllw	21228		
:	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	r's Signature						

DHMH 17 Rev 1/2001

JUL 2 7 2004

ORIGINAL Aparks

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Savage Month Year 94 06:36PM 2004 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 10h If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 3,1966 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 □ F Yrs MARYLAND Director 219 86 0065 37 Usual Residence of Decedent with the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or iteme 23a or 28a-f show other treumatic event, to Ms. Jical Examinar must be notified at 1 Tyes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 U.S.A. 3436 ELMORA AVENUE death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelith and Mental thygiene. Importent: If item 27 is marked other than "naturel; or item any finury or other traumatic event, II a Musical Essuinar any finury or other traumatic event, III a Musical Essuinar X Never Married 2 Married 1 Yes 2 No 3altimore, Maryland 21215-0036 ğ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNEMPLOYED NONE 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ALBERT SAVAGE FERN HICKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NACOLE TAYLOR (SISTER) 3436 ELMORA AVENUE BALTIMORE, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) ZION CEMETERY JULY 28,2004 BALTIMORE, MD. 21 Signature of Funeral Service Licenses any in CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTIMORE, MD. 21213 23a. Part. Enter the disease, or complications that caused the earth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 14 day Immediate Cause (Final slabiata Physician andida tungemic disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (coas a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) ettending physician P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼No 24a. Was an certificate has 21X No 1 Yes Hospitel or Attending Physicien: To 24 hours after death.
 Funerel Director: After this certificat sletch filled in by the funeral director, px 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 To the 29c. License number 29b. Signature and-title of certifie 29d. Date signed (Month, Day, Year) July 25, 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21287 mo 600 N. Wolfe assaretti 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 2 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Herbert Smith July 21 2004 11:10 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 707 Kennebec Ave. Takoma Park Montgomery 8. Date of Birth
(Month, Day, Year)
April 25,1950 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Yrs. 54 Director 008-38-0921 Vermont Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Exemt er must be notified at 10d. Inside City Limits Montgomery Maryland 1X Yes 2 □ No Director Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 707 Kennebec Ave. 20912 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or her any injury or other traument. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Sive Year or Dates: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professor University Studies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Seymour Smith Annette Cohen ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Smith / Wife 707 Kennebec Ave., Takoma Park, MD 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) July 23. Chesapeake Crematory Beltsville, MD 21. Signature 22. Name and Address of Facility
Rapp Funeral and Cremation Services of Funeral S M00382 933 Gist Ave., Silver Spring, MD Saple & Johnson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Malignant Brain Tumor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ pe 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has perform 2 💢 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division or Attending 1 XNatural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 T Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a To the Funerel [Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D0040948 July 22, 2004 0 30. Name and ad ss of person person mpleted cause of death (Item 23a) (Type, Print) 2101 Medical Park Dr. #210, Silver Spring, MD Julie Fox M.D.; 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 sparles Registrar JUL 2 7 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death (First, Middle, Last) 2. Date of Death **Physician** /Medical Town, or Location of Death **Examiner** 4c. County of Death If Under 1 Year | Months Days Funeral Hours Min Director Usual Residence of Decedent 10b. Count or Location 10d. Inside City Limits or 28a-f show other traumatic avant, the Medical Examiner must be notified at Completed by Funeral Director 1 → Yes 2 □ No Oitizen of What Country? 72 hours after death with or Items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces? 14. Race - American Indian, Black, White, etc. 1. Never Married 2 Married 1 Yes 2 1 If Yes, Give Year or Dates: 2 1 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use gained) 15. Decedent's Education (Specify only highest grade complete 16b. Kind of Business/Industry filed within Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If itam 27 is marked other than " Arv (0-12) Be 2 permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trai once. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CANCEL IteRine Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician at s the burial-1 Due to (or as a consequence of) Box 68760, Physician/Medical as attending use IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy for Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. | signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ cate has been sig. 2 1 No Be Completed 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has Division of Vital Hospital or Attanding Physician: the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 🗌 Yes 2♥ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 8303

State Registrar

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JUL 2 7 2004

Na and address of person

31. Date filed (Month, Day, Year)

32. Registrar's Signature

who completed cause of de

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Sports

rades St Baltmore MD 21204

(Item 23a) (Type, Print)

			For Stete	State of	f Marylar	-	artment of H		Mental Hy	giene		
		_	Registrer		-	Cei	tificate of	Death	2. Date of De	Reg. No.	04_	23602
	Physici	an	Decedent's Name (First, Middle Evelyn Margare						Month July	Day	Year	3. Time of Dealth
	/Medic Examin		4a. Facility Name (If not institution		nber)		4b. City, Town, or	Location of Dea			2004 nty of Death	3:50 P M
	LXamii	C1	Brightview Ass	isted Liv	ing		Cato	nsville			Balt	imore
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛱 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs		th av. Year)	9. Birth	place (State or Foreign
	Director		213-26-4491 Usual Residence of Decedent	I L M ZXIF	72	Yrs.			Jan. 5	, 1932		yland
	/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	Man B-f sh	tor	MD How	ard			Elkric	lge				1 ☐ Yes 2 🕅 No
	or 28	Director	10e. Street and Number			-	10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	s 23a	ral	5995 Rowenberry					21075			ed St	
39	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "neturel", or Itams 23a or 28e-f show imetic event, Ite Modical Errapited to a the notified at	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 XDivorced	Armed Fo	2 X No e	'	Vas Decedent of H f Yes, specify Cuba I ☐ Yes ② No	ispanic Origin? (s in, Mexican, Puel Specify:	Specify Yes or No rto Rican, etc.)		ace - Americ lack, White, cify: W	
21215-0036	72 ho	Completed	15. Decedent (Specify only highes	's Education		16a. Deced	lent's Usual Occup	ation	orkina	16b. Kind of	Business/In	dustry
7	vithin ne. han *	mpi	Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of work done o					
2	filed w Hygier other th	CC	17. Father's Name (First, Middle, I	ast)		P	ersonnel		r .me (First, Middle		nagem	ent
Maryland	ld be ental ked o	To Be	August Kelch	,					a Phiefe		<i>amo</i>)	
ary	2 should and Men is marke eumetic	_	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Street				π, State, Zip	Code)
	is 1 and 2 should of Health and Men item 27 is marke other treumetic		Kimberly Spence	e Daught			Summit A		Halethor	pe, MD	21227	
altimore,	ges 1 t of He If iter or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from S	State 20b. F	Place of Dispo cemetery, cren	sition (Name of natory or other place	e)	Date	20c. Location	- City or To	own, State
Ē	t. Pacrimentinent:	1	Opposition 5 ☐ Other (Sp.		Lou	don Pa	rk Cemete	ry 7-26	5-2004	Baltim	ore,	MD
Ba	permit. Pages Department of the Importent: If ite any injury or of once.		21 lignatule of Funeral	SUD	Me	13.	. Name and Addres 28 Sulphu	r Spring	g Rd., A:	rbutus,		1227
			23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on e	aused the deat ach line.			g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	or as a conseq		romA	(13ra	in Cai	nun		
	Examiner			Due 10 (or as a conseq	luence or):	.~					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):	011							
	acuted ind transit	Examin	Cause (Disease or injury that initiated events	с.	MOOH	2 you	dvom					
Ď,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a conseq	uencérof):	a					
9/80		dicai		d. 15-17	7/0	Morey	rmin					
O. Box	death certi e attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 X No 9 ☐ Unknown No		nth 2 ∏ Feta ant at time of d	ll death 3 🗌	Ectopic pregnancy Other (specify)				ate of delive	ery Day Year
J.	law requires that the de as been signed by the a 2 should be detached f	by Ph	Part II. Other significant conditio	ns contributing to de	ath but not res	ulting in the ur	iderlying cause give	en in Part I.	23e. Did to	obacco use ço	ntribute to th	ne cause of death?
g	w requires been sign should be								101	Yes 2000	3 🗌 Prob	ably 4 Unknown
II Kecords,	The ate ha	Completed							24a. Was autop perfo 1 Yes	an 24b osy rmed? 2)X No	prior to cor death?	psy findings available impletion of cause of
Vital	Physicien: Th rthis certificate ral director, paç	Be	25. Was case referred to medical examiner?	Hospital:			Othy		ath (Check only o	6.7		
0	hys Sid I dis	- To	1 Yes 2/No 27. Manner of Death	1 1		ER/Outpatien 28b. Time of		4 LI NUISING F	dome 5 Resident		ther (Specify	HOSPICE
0	nding P tth. :: After t e funera	atior	Natural 5 Pending		of Injury or, Day Year)	Injury	28c. Injury Work M 1 □ `	(? Yes 2 ∐No				
DIVISION	er dea	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At ho	ome, farm, stre	eet, factory, office		28f. Location (S City or Tox		ber or Rura	l Route Number,
5	ital or irs aft ral Dir led in			n in in								
	To the Hospital or Attending Pwithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical	29a. Certifier Certifying (Check only one)	g Physician: To the examiner: On the ba and mann	sis of examina	owledge, death tion and/or inv	occurred at the timestigation, in my op	e, date and place pinion, death occu	e, and due to the urred at the time.	cause(s) and n date and place	nanner as st , and due to	ated. the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier				29c. License	number		29d. Date sign	_	1
	2		MAN				リグ	11/8		July	23,	2004
	.0		30. Name and address of person v	who completed cause	of death (Item	F (.1	1	IN DLA	()	in his	Mal	2004
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa		vmbic	100 121	1, WIN	Ami 1160	. 1	-1017
	Registr	S 80	1111 2 7 20	na Pera	as H.	book	20					

			1 - For State Registrar		4.	Marylar				lealth a			g. Ne	1000	, 2;	3603	
	Physici /Medi		1. Decedent's Name (First, Mid	ile, Last)	e		Sce	10	1.1			2. Date of Deat Month	Day	Yes		ime of Death	
)	Examir		4a. Fecility Name (If not instituti	-						Location of	of Death		4c.	County of D			
			St. Elizabe	-			for a district of the		Balti r 1 Year	more If Under	24 Usa			Balti			
	Funeral Director		5. Social Security Number 212-05-2288 Usual Residence of Decedent	6. Sex 1 ☐ N	M 2∭0 F	90	last birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Dey, Feb 8,	Yeer) 1914	9. M	Birthplece (: Country) arylai	State or Foreign nd	
1215-0036 within 72 hours after death with the Maryland	Maryland -f show isd at	tor	10a. State 10b. Coun	y imore	e Baltimore									10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	with the	Director	10e. Street and Number											10g. Citizen of What Country?			
	s 23e	ra	3320 Benson A							227				USA			
	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "natural" or items 23s or 28s-f show event, it a Medical Expoliter count by notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rried	1 ☐ Yes 2 X No				Mas Decedent of Hispanic Origin? (Specity Yes or I f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No Specify:				No- 14. Race - American Black, White, etc Specify: Wh:				
215-0036	nin 72 ho in *natur M. circil	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)						ork done d	durina mos	t of worki	ng	16b. Kir	nd of Busine	ss/Industry		
2121	filed with Hygiene ither the	om	Elementary/Secondary (0-12)		0	01 5+)		hous	ewif	e				own home			
0		To Be C	17. Father's Name (First, Middle John Benedie		st							(First, Middle, M Harvey					
Mary	od 2 sh lith and 27 Is m traum		19a. Informant's Name/Relation Donald Schott		e, Print)							A Route Number,					
altimore,	Pages 1 ar nent of Hea int: If item 3		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ※ Donation 5 ☐ Other.		20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town,								ate				
Baltir	permit. Pages Department of Important: If ii any injury or o		21. Signature of Funeral Service Rona Ld		ide Di	rector	s St	Name a	nd Addres	is of Facility	y Sard	655 W.	Bal:	timore	Stre	et	
	Pnysician		23a. Pert1. Enter the disease, shock, or heart failure. Li Immediate dause (Final disease or condition resulting in death)	complicationly one	ations that cau cause on eac		th. Do not ent	01 410 1110	4	y, such as	cardiac c	a respiratory arre	st,		Interv	eximate al Between t and Death	
	/Medical Examiner		Sequentially list conditions,	b.													
	nd nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter or John in Cause (Disease or injury that initiated events	c .	Due to (or as a consequence of):												
8760,	ate be executed hysician and the burial-transit	cal	resulting in death) Last	d.	Due to (or as a consequence of): d												
.O. Box 6	law requires that the death certificate be executed as even signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	230		n 2 ∏ Feta it at time of d	Ideath 3	Ectopic p Other (sp					2:	3d. Date of o	delivery Day	Year	
ecords, P	uires that signed b	by	Part II. Other significant condi-	ions contri	ibuting to deal	h but not res	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did tob				e of death?	
õ	w requir	lete	24a. Was an								24b. Were autopsy findings available						
Ť	The ate page	Completed										autopsy perform 1 Yes 2	ed?/	prior to death	o completio	n of cause of	
Vital	Physician: Tribis certificater al director, p	Be	25. Was case referred to medic examiner?		spital:				Othe	r	-14	ath (Check only one)					
ō	Phys r this ral di	. To	1 Yes 2 2 No		1 ☐ Inpatient 2 ☐ ER/Outpatier							Home 5 Residence 6 Other (S			ecify)		
Division	Attending P r death. ector: After I by the funera	catlon	1 Defoural 5 Pend 2 Accident inves 3 Suicide 6 Could	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No				28d. Describe how injury occurred									
	7 5 5 6	Certification;	4 Homicide deter	mined			ome, farm, stre					8f. Location (Str. City or Town,	State)			Number,	
	To the Hospital of within 24 hours at To the Funers! D completely filled in	Medical	one)	Examine	r: On the basi and manner	s of exam≀na	owledge, death tion and/or inv	occurred restigation	at the tim , in my op	e, date and inion, deat	d place, a h occurre	nd due to the car ed at the time, da	use(s) a te and p	and manner place, and di	as stated. ue to the ca	use(s)	
1	with To 1	2	29b. Signature and title of pertif	PC	Kor	28		290	i. License	95	/		1	signed (Mod	04	ear)	
			30. Name and address of person EMWD,	who com	pleted cause	of death (Item	1232) (Type,	Prior)	2/ d	1.41	y) (Short	1/1	1> 2	1210		
Ç.	Sta Registr		31. Date filed (Month, Day, Yea		32. Reg	istrar's Signa	ture	10-	1.					-	13		

			1 = For State Registrar	State of Mar		partmen ertificat			and Mer		ene	0	226	0.1			
		- 11	Decedent's Name (First, Middle, Last)							Date of Death	favor -		3. Time	of Death			
	Physici Medic		ALice Sparkman							Month July 16	Day 200	Year 14	9:47	PM M			
	Examir		4a. Facility Name (If not institution, give					Location of	f Death			y of Death	1				
3.0		-0	Prince George's				into		741100				Georg				
-444	Funeral Director		5. Social Security Number 6. Sec. 226–16–8027	114 0177 5	n yrs. last birthda 3 Yrs	Months	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Y In 22,		9. Birth Cou	place (State intry)	or Foreign unk			
	pur *		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or	Location							10d. Inside (Tity Limite			
	Aaryk sho	ō	DC		Washir									s 2 No			
	the A	Director	10e. Street and Number			10f. Zip	Code			100	. Citizen of	What Cou					
	3a or	ī	5000 Nannie Helen	Burrough	Avenue			2001	a				,				
	death	Funeral		12. Was Decedent Eve Armed Forces?		3. Was Deced	lent of Hi			Yes or No-	14. Rad		ican Indian,				
36	be filed within 72 hours after death with the Maryland hat Hygiene. Independent than "netural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	unk	1 Yes		Specify:	, rueno Aica	in, etc.)		ick, White, fy: b1a					
9	2 hou		15. Decedent's Edu	cation	ation 16a. Decedent's Usual Occupation					112 le 16	b. Kind of B			1			
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life	ive kind of wor e. DO NOT us	se retired	iuring most)	of working	unk	unk			unk			
2	filed wi Hygien other th	Con	unk un	k													
Baltimore, Maryland 21215-0036	ld be fill ental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last)			u	nk	18. Mother	r's Name <i>(Fi</i> i	rst, Middle, Ma	iden Sumar	ne)		unk			
any	ges 1 and 2 should be 1 of Health and Mental If Item 27 is marked or or other traumatic even	-	19a. Informant's Name/Relationship (Ty	•						ute Number, C			p Code)				
Σ.	D =			Prince George's N					l Driv		nton, M						
ore	Pages 1 nent of H int: If itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		20b. Place of Dis cemetery, o	sposition (Nan crematory or o	ne of ther place	θ)	Date	20	c. Location	- City or T	own, State				
Ë	t. Pa tmen tant: ijury		*4 □ Donation 5 ☒ Other (Specify)		7												
Bal	permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other ODES.		21. Signature of Funeral Survice License	Vade, Dire	tor	State A Baltimo	Anato Anato Ore,	of Facility Omy Bo MD 2	oard 6 21201	55 W. E	Baltim	ore s	Street				
			23a. Part 1 Enter the disease, or combine shock, or heart failure. List only or Immediate Cause (Finat	Onset and Death										tween			
	Physician /Medical		disease or condition resulting in death)	a. Cardiac arrhythmia Due to (or as a consequence of):										200			
	Examiner	niner	Examiner	Sequentially list conditions,	b. hypertension Due to (or as a consequence of):												
	ed sit			nine	Sequentially list conditions, if any, leading to immediate causs. Enter Uncorning Cause (Disease or injury	atherosclerotic heart disease											
Ć.	The law requires that the death centificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a consequence of):													
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o.	the de	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	4 □ Pregnant at tim 9 □ Unknown	e of death	5 ☐ Other (spe	өсту) <u> </u>						,				
۵.	res that the digned by the be detached	Ph/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use co							co use cont	ribute to t	he cause of	death?				
rds	uires n sign	q p	dysplagia, deppre	ssion, ano	rexia, d	lementi	a, D	M		1 🗆 Yes	2 🗆 No	3 Prot	bably 4 🗆	Unknown			
Ş	w require s been significant	lete								24a. Was an	24b.	Were auto	psy findings	available			
æ	The law cate has page 2:	Completed								autopsy performed 1 Yes 2	d?	prior to co death?	mpletion of d 2⊟No	cause of			
ita		0	25. Was case referred to medical					26. Place		neck only one)	1140	103	20110				
>	Phyaician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	ospitaf: 1 ☐ Inpatient	2 ER/Outpat	ient 3 DO	The second secon				☐ Residence 6 ☐ Other (Specify)						
0 0	ng Pł fter tł meral	:uo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time	of 28	Bc. Injury Work			Describe how							
Sio	Attending ir death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No					lo								
Division of Vital Records,	al or Attated after dif Direct		4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				nber,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illed in by the funeral director.	edical (29a. Certifier 1 Certifying Physical Checklony 2 Medical Examinate	sician: To the best of n	amination and/or	eath occurred a investigation,	at the tim in my op	e, date and inion, death	place, and o	due to the caus t the time, date	e(s) and ma and place,	inner as st	tated.	s)			
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated	J.	29c	License	number		29d.	Date signe	d (Month,	Day, Year)				
)	F 3 F 8		MANDATTA	KIM.	10 - M		1	221/2	35		- /		-				
			30. Name and aduress of person who co	mpleted cause of deat	h (Jt - 23a) (Tvc	oe, Print)	1.	1	, –		- 7	40	/				
			acquaret	a QO	Frais	en to	ine	e He	earge	s me	1. Ce	nt	21				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	An	u.Ko	/	- 0								

			State of Maryland / Department of Health and Mer	ntal Hygien	e
			1 - State Registrar AMEND ITEM #18 PER FH C833 7 PET TO CALL OF Death	Reg. N	2004 23605
	Physici /Medio		CILAT		ay Yeer 3. Time of Death AM
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GNYNN OFIC		ic. County of Death ALTIMORE
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Iff Under 1 Year If Under 24 Hrs. 8	Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	30,1	10d. Inside City Limits
	the Mar r 28a-f et	Director	Maryland Baltimore Gwynn Oak 100. Street and Number 101. Zip Code	10g. C	1 Stres 2 □ No
	eath with	eral Di	7511 Liberty Rd. 2/207 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify	. Von ar No	14. Race - American Indian,
920	within 72 hours after death with the Maryland ane. then 'neturel', or items 23e or 28a-f ehow te Madical Examirer must be milling at	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes, Specify Cuban, Mexican, Puerto Rica 1 Yes, Specify Cuban, Puerto Rica 1 Yes, Specify Cuban, Puerto Rica 1 Yes, Specify Cuban, Puerto Rica 1 Yes, Spec	an, etc.)	Black, White, etc. Specify: Black
215-0036	in 72 ho 1 "netur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/industry
2	filed with Hygiene other ther	e Com	Elementary/Secondary (0-12) College (1-4or 5+) We der 17. Father's Name (First, Middle, Last) 18. Mother's Name (First)	Be Beide	thlehem Steel
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Baltimore,	Pages 1 nent of He int: If iter iry or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Place of Disposition (Name of cametery, crematory or other place) 7/26/5	2004 T	Location - City of Town, State
Balti	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 25. Name and Address of Facility	unera	1 Home 201
	横		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock or heart failure. List only one cause on each line.	spiratory arrest,	Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. METASTATIC CARCINOMA or Due to (or as a consequence of):	FLIVE	
	Examiner	ner	Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
, Ć	cate be executed physician and the burial-transit	Examin	Cause (Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
68760,	ficate be physicials the bur	edicai	d		
.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes \ 2 \] No 9 \[Unknown \] 23c. If yes, outcome of pregnancy 1 \[Live birth 2 \] Fetal death 4 \[Pregnant at time of death 9 \] Unknown 5 \[Other (specify) \]		23d. Date of delivery Month Day Year
Q _	ires that the de signed by the d be detached	by	Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	use contribute to the cause of death?	
Score	e law requir has been si je 2 should	Completed		1 Tes 2	24b. Were autopsy findings available
Vital Records,	iician: The certificate ha	e Com		performed? 1 ☐ Yes 2 ☐ N	prior to completion of cause of death? 1 ☐ Yes 2 🗫 No
i N	S 0 0	To B	examiner?	L-	6 □Other (Specify)
on of	ding Ph th. After thi funeral		27. Manner of Death 1 Phatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Injury at Work?	Describe how inju	
Division	or Atten after deal Director: in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital within 24 hours a To the Funeral completely filled	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and and manner stated.	due to the cause(t the time, date ar	s) and manner as stated. Ind place, and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier 29c. License number	29d. D.	ate signed (Month, Day, Year)
,	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C - NAVI, 86 20 LISENTY PLAZA MA	U MO	71137
£	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 1111 2 7 7004	11/10	- "

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 9:48 A M Courtney 07 22 Μ. Terry 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3211 Ripple Road Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Days Hours 1 対 M 2 □ F 56 Director Yrs 219-50-3755 04 07 48 Roanoke. VA. Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23a or 28a-f show traumatic event, If e Marical Exertities must be notified at 1√ Yes 2 No Director Washington D.C. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20011 5205 14th. Street N.W. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. s filed within 72 hours after de I Hyglene. othar than "natural", or Itam 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) University of the Elementary/Secondary (0-12) College (1-4or 5+) : 1 and 2 should be filed wi Health and Mental Hygien tem 27 Is marked othar th College Professor District of Columbia 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest R. Terry, Sr. Vivian O Hines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Ernest R. Terry, Jr./Brother 12435 Diploma Drive, Reisterstown, Md. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery 7-28-04 Washington, D.C. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marshall's Funeral Home marshall 4217 9th. St. N.W. Washington, D.C. 23a. Pap. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiopulmonary Disease /Medical Due to (or as a consequence of): **Examiner** Advanced Metastatic Prostate Cancer if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the land of the cause (Disease or injury that in the cause of the cause (Disease or injury that in the cause of th Due to (or as a consequence of): Examiner physician and s the burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Renal Insufficiency 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2□ No 2K No 1 🗌 Yes the Hospital or Attanding Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence SCOther (Specify Father's Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 🙀 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred After Certification: 1 🙀 Natural 2 □ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours aft le Funaral Di letely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. within 2 To the of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) ပ MD30186 7-23-04

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Baltimore, Maryland 21215-0036

Box 68760

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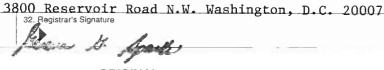
Division of Vital

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Asim, Amin, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physic /Medi		Robert William		•				JÜLŸ	16, ^{Day} 200	1	10:10 PM	
7	Examiı	ner	4a. Facility Name (If not institution, gi HARBOR HOSPITA				Town, or Loca BALTIMO	RE CI	TY	4c. Cour	ty of Death		
9	Funeral Director		219-62-6604	Sex 7. Ag 1 X 1M 2□F	e (In yrs. last birth	day) If Under Months		Jnder 24 Hr ours Min	(Month.	Birth Day, Year) 2, 1954	9. Birthi Cou Mar	place (State or Foreign http:) yland	
~/	show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits	
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Maryland 21215-0036	after or Ita	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	Ever in U.S.	13. Was Deced If Yes, spec		ic Origin? (exican, Pue ecify:	Specify Yes or nto Rican, etc.)		ace - Americ ack, White, ify: Whi	etc.	
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alt	permit. Pages 1 and 2. Department of Health ar Important: If Itam 27 Is any injury or othar trau	(21. Sin aura of Funeral Service Lice	370h	114.0							Lansdowne	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month 7:30 AM laylor 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore ienter If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 M 2 7 F 84 228-22 - 9084 Usual Residence of Decedent Vrs Director 5/29/20 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show treumetic event, the Medical Exerciter must be nutified at 1 ☐ Yes 2 ☑ No Director Northum berland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a Road 225 39 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 TYAS 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salons Beautician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bessie Jackson harles 19a. Informant's Name/Relationship (Type, Print) (Huy ban 📗 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If itam 27 ls 71 Fox Point Rd Reedville, VA Floyd Edward laylor 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemetery 2004 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
The Joseph L. Russ
2222 W. North Ave. 21. Signature of Funeral Service Licenses PA Harris, 7.71 21216 Battimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DERINE **Physician** nenths disease or condition resulting in death) Caucer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Juiscass or injury Due to (or as a consequence of) Examiner Cause (Disease or that initiated events the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? is certificate has director, page 2 a 2 \(\text{No.} 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) WSPL 1 ☐ Yes 2 No Certification: To this After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D58303 July 23 2004 30. Name and address of person who completed cause of death (Item 23a) (Type Print)
ARON I WHILE IN 6601 N. Charles of Rational Marie Mari APRON

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

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	Examin		4a. Facility Name (If not institution, give stree	et and number)		_		Location of	Death			County of Dea	ath	
			Home; 10 Haymarket					Hall				Baltimo		
	Funeral		5. Social Security Number 6. Sex XIX M		rs. last birthday) 43 Yrs.	If Under Months	Days	If Under 2 Hours			h LOZ y, Year)			State or Foreign
, etc	Director		Usual Residence of Decedent		10 10				9	ct. 1(), 19 (63	ıryla	nd
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	and 2 alth au n 27 ls		Roxanna Valenza	(Wife)	10 Ha	aymark	ket (Court	Pe	erry H	la11,	MD 21	236	
J.e.	es 1 and 2 of Health if item 27 I	1 7	20a. Method of Disposition XX Burial 2 □ Cremation 3 □ Remo	Į.	b. Place of Dispo	sition (Nam	ne of ther place)	Date			cation - City o		ate
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Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signatura of Funeral Service Ligensee	uputo	B 3	Name and urgee: 631 F	Address -Hen alls	s of Facility SS-Se: Road	itz Fi Bali	unera] timore	L Hon	me, Inc	21	211
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cannot be shocked to the cannot be shown to	ons hat caused the deause on each line.	eath. Do not ent	er the mode	of dying	, such as c					Appro	oximate al Between
	Physician		Immediate Cause (Final disease or condition resulting in death)		HSTN	ma							Onse	t and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):									
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):									
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discuss of Figure 1) that initiated events c.											
o,	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as a cons	sequence of):									
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9	leath certific attending p	/Me	IF FEMALE: 23c.	f yes, outcome of pre-	gnancy							23d. Date of de	li	
Вох	death a atten	cian	in the past 12 months?	1□Live birth 2□F 4□Pregnant at time o	etal death 3	Ectopic pre Other (spe					-	Month	Day	Year
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Records, F	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions contrib	uting to death but not	resulting in the u	nderlying ca	ause give	n in Part I.			obacco u: 'es 2[se contribute t ∃No 3⊟P	o the caus	unknown
cor	w require been si should?	iete								24a. Was	an	24b. Were a	utopsv fine	dings available
Re	icien: The lav certificate has rector, page 2	omp								autop perfor 1 Yes	med?	prior to death?	completio	n of cause of
Vital		Be C	25. Was case referred to medical examiner?					26. Place	of Death (C	heck only o		1 1 1 6 5	2014	0
of V	Physicien: this certific ral director,	70 E	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)											
o u		on:		8a. Date of Injury (Month, Day Year	28b. Time of Injury		Bc. Injury Work			. Describe h	ow injury	occurred /		
Division	Attending r death. sctor: After	icat	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury - A	t home farm str	M eat factory		es 2 N		Location (S	treet and	d Number or R	ural Route	Number
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	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 12 Certifying Physicial 2 Medical Exeminer:	n: To the best of my line on the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred a	at the time in my op	e, date and inion, death	place, and occurred a	due to the o	ause(s)	and manner a place, and due	s stated. to the ca	use(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and the state of t		29c.	License	number			29d. Date	signed (Mon	h. Day, Ye	ear)
	r>=0		Va 8 Pa	1167			D	4277	79		7	122 01	4	
	10		30. Name and address of person who compl	eted cause of death (I	Item 23a) (Tyge,	Print)	0,1	Bul	Alma	o M	ຄ	71134	J	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	iuit	M	YM.	NITTE	1/1	ν	L LIND		
ŝ	Regist	ar	JUI 2 7 2004	Sanera	- 19	100	uls	/						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Y 20184 **Physician** LILLIAN MARIE VOELKER 21:14 /Medical 4c. County of Death Haltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center OWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAY 3, 15 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F 70 1934 MARYLAND 216-30-5122 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD BALTIMORE FREELAND Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 20806 SOUTH RUHL ROAD 21053 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE þ 3 ₺ Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 2008. WILLIAM J. SCHMIDT LILLIAN MARIE DANNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GINA TAMBERINO 21315 GUNPOWDER RD. MILLERS, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MORELAND CEMETERY 07/31/2004 PARKVILLE, MD. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 21. Signature of Funeral Service Licensee 16924 YORK RD. MONKTON, MD 21111 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINOMA LUNG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, frank, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760. by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year be detached for 4☐ Pregnant at time of death 5 ☐ Other (specify) o. 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death3
1 → 8 2 → No page 2 1 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptifier D28244 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 FOWZIA TAQI M. D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 7 2004 Registrar

			1 - For State Registrar	State of N	Maryland /		artment rtificate			and M	-	giene	001		23611
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	Examir	ner	601 Lafayette S		•				de (۵	46.	County of	rfor	·d
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	or 28	Dire	10e. Street and Number				10f. Zip					10g. Citi	zen of Wh		ntry?
	sath w	erai	601 Lafayette S	12. Was Decede		12.1	Mac Deced	210		-1-2 (0-				USA	to dia
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 Ia marked other than "natural", or items 28 or 28e-f show other traumatic event, ITE Modeal Exeminations Item Traumatic event, ITE Modeal Exeminations Item Traumatic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Force 1 Tes 29 If Yes, Give Year or Date:	\$? 1 No		f Yes, speci		spanic Origin, Mexican Specify:	jin? (Spe , Puerto	ecify Yes or No Rican, etc.))-		White,	ean Indian, etc. White
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Baltimore,	permit. Pages 1 and 2. Department of Health ar Importent: If item 27 la any injury or other trau		21. Signature Fun III	My c Oma	ld	C 22	Name and remat	Address 1001	SOCIE	ty (of Mary Balti	land	, Inc	2.	28
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	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Medicai Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the besiminer: On the basis and manner	of examination a	ge, death ind/or inv	occurred at	the time	e, date and nion, death	place, a	and due to the co	cause(s) a	and manno	er as sta	ated. the cause(s)
	ro the	Me	29b. Signature and title of certifier	7 /	siaiou.		29c.	License	number			29d. Date	signed (A	Month, D	Day, Year)
			I ful ()	las 1	mo			D:	305.	25		7	/23	12	004
	り		30. Name and address of person who	completed cause of	death (Item 23a)	Туре, F	Print)	Har	605	ST.	BAU	Mer	e no	2	21204
1	Sta Registr	947	31. Date filed (Month, Day, Year)		strar's Signature	,	bour	2							

	State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Bag No O	ole.
Physician /Medical	Decedent's Name (First, Middle, Last) 2. Date of Death Month Day	Year 3. Time of Death 1208 p M
Examiner Funeral	A. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ac. County N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) The security Number of the security Number of N	of Death 9. Birthplace (State or Foreign Country) Maryland
r 28a-f show routified at irector	Sual Residence of Decedent Da. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Baltimore	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
0 69	De. Street and Number 10f. Zip Code 10g. Citizen of V 5225 Kramme Avenue 21225 U.S	
al', or items	1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	e - American Indian, k, White, etc.
than " the Men	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refired) Recently Secondary (0-12) College (1-4or 5+) Grocery Clerk Basics	siness/Industry 5 Food Service
Mental H arked ott atic even	7. Father's Name (First, Middle, Last) Bain Webster 18. Mother's Name (First, Middle, Maiden Sumam Mary White	
f Health and item 27 is m other traum	9a. Informant's Name/Relationship (Type, Print) Diana Webster / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 5225 Kramme Avenue Baltimore, Mary	/land 21225
ant: If ury or	1 ABurial 2 Cremation 3 Removal from State cometery, crematory or other place) 4 Donation 5 Other (Specify) (Cedar Hill Cemetery 7/28/2004 Baltimo:	City or Town, State re, Maryland
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ysician and le burial-transit le burial-transit cal Examiner	23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final lisease or condition esulting in death) Due to (or as a consequence of): b. Due to (or as a consequence of): a. Due to (or as a consequence of): c. Due tr (or as a consequence of): d. Due tr (or as a consequence of):	Approximate Interval Between Onset and Death 20 4rs
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within 2 within 2 To the P Complete	9b. Signature and title of certifier 29c. License number 29d. Date signed 29d. Date signed 200. Date signed	(Month, Day, Year) 24. 2004
State Registrar	1. Date filed (Month, Day, Year) 32. Registrar's signature Apouls Apouls	

			_ FUI	partment of Health and Mertificate of Death		ene 2004	23613
	Physici		1. Decedent's Name (First, Middle, Last) Lillian, Whitesell		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Ī	Funeral Director		5. Social Security Number 216 24 3432 6. Sex 1 日 M 2 哲 79 Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y June 16,	9. Birth	place (State or Foreign intry) .rginia
	Maryland f show	ior	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Anne Arundel Glen B				10d. Inside City Limits 1 ☐ Yes 2X No
	with the	Funeral Director	10e. Street and Number 1004 Stewart Lane	10f. Zip Code 21060	10g	. Citizen of What Cou	ntry?
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show Its Madical Examinar mast be mullified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	etc.
21215-0036	be filed within 72 ho ital Hygiene. d other than "natur event, Ire Maxical	Completed	(Specify only highest grade completed) (Giver inferior inferior (Giver inferior infe	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) MEMAKET	ing 16	o. Kind of Business/Ir	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, ITEM	To Be C	17. Father's Name (First, Middle, Last) Sidney Adcock	Luc	y Duff		
	1 and Health em 27 ther tr		David Whitesell / Son 113	position (Name of	n Burnie,	ity or Town, State, Zi Maryland c. Location - City or T	21060
Baltimore,	t. Page: rtment o rtant: If njury or		1 Q Buriar 2 ☐ Cremation 3 ☐ Hemoval from State 1 ☐ Donation 5 ☐ Other (Specify) Cedar F	ematory or other place) Hill Cemetery 7/28, 22. Name and Address of Facility Co	/2004 Ba		Maryland
B	permi Depa Impo any ir		23a/Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List get one cause on each line.	1001 Ritchie Highwa	y Balti	lmore, Mar	yland 21225 Approximate Interval Between
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of Vita	Physician: Th r this certificate ral director, pag	: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA Other: 4 Nursing Ho	me 5 Residence	e 6 Other (Special	(y)
Division	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Injury) (Month, Day Year) 28b. Time (Injury) (Specify)	Work? M 1 □ Yes 2 □ No		at and Number or Run	al Route Number,
_	To the Hospitel or A within 24 hours after To the Funeral Directompletely filled in by	edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the deal	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
•	To th within To th compl	Me	29b. Signature and eitle of certifier ACA ACA ACA ACA ACA ACA ACA A	29c. License number		Date signed (Month,	- 1
	5		30. Name and address of person who completed cause of death (Item 23a) (Type Steven Epstein 22 South Gre	ene Street, Defairtment	of Meclicine, (University of M	langland, Balto, MI
DL	Sta Registi	rar	30. Name and address of person who completed cause of death (Item 23a) (Type Steven Epstein 22 South Green 31. Date filed (Month, Day, Year) 32. Registrar's Signature	pouls			31201

	Physici		1 - For AMEND ITEM # Registrar 1. Decedent's Name (First, Middle, La		d / Departme 3 7/28/19/ea	ent of Health and of Death WALKER	Mental Hygiel Reg. 2. Date of Death Month	0001 00
100	/Medi Examir		4a. Fecility Name (If not institution, give	ESPKins / Esp	1.tol 2	ty, Town, or Location of Dea	City	4c. County of Deeth n/A
	Funeral Director		5. Social Security Number 212 48 1415 Usual Residence of Decedent	Sex 7. Age (In ýrs. 1 √ M 2□ F 5	Month	der i Year If Under 24 Hr. Is Days Hours Min		9. Birthplece (State Country) 946 MARYLAND
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show licel Evantinar must be rodified at	Director	10a. State 10b. County MD N/A 10e. Street and Number		y, Town or Location IMORE	Zip Code	100	10d. Inside 1 ☒Y€ Citizen of What Country?
	ath with t		1908 E. FEDERAL S		2]	213	U.S	5.A
920	72 hours after death with the Marylan natural; or Items 23a or 28a-f show dical Examinat must be rollified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue 2 XNo Specify:	specify tes of No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	c _ 3	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO	work done during most of wi	orking 16b	. Kind of Business/Industry
Ind 212	be filed ital Hyg id othe event,	Be	12th 17. Father's Name (First, Middle, Last ANDREW G. WALKER)	SELF EMPI	OYED OWNER 18. Mother's Na MINA J.	ame (First, Middle, Maid	DDLE CONFECTION Den Sumame)
Maryland	s 1 and 2 should be f Health and Mental item 27 is marked o other traumatic eve	T _o	19a. Informant's Name/Relationship	Type, Print)		ess (Street and Number or F	Rural Route Number, Ci	ty or Town, State, Zip Code)
Baltimore,	Page nent o ant: If ury or		TRACEY WALKER (DA 20a. Mathod of Disposition 1 Busies 2 Cremation 3 I 4 Domation 5 Other (Species	Removal from State	Place of Disposition (I	Name of	Date 20c	MARYLAND 21205 Location - City or Town, State PALTIMORE, MD
Balt	permit. Page Department of Important: If any injury or once.		2) Senature of Funeral Service Lice	1. Jornay	1412	E. PRESTON ST	REET BALTI	CRUGGS FUNERAL MORE, MARYLAND
>	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. HEART F	AILURE	node of dying, such as cardi	ac or respiratory arrest,	Approxim Interval B Onset an
÷	Examiner	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence DILATED Due to (or as a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Du	CARDION	MOPATHY		140
68760,	cate be executed physician and the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	c. A) Due to (or as a conseq	uence of):			9 ye
.O. Box 687	death certifi e attending d for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	ıldeath 3⊡Ectopi	c pregnancy (specify)		23d. Date of delivery Month Day
<u>α</u>	requires that the d een signed by the hould be detached	þ	Part II. Other significent conditions	contributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobacc	co use contribute to the cause o 2 XXNo 3 ☐ Probably 4 [
Records,	e law has b	Completed					24a. Was an autopsy performed	
Vital	sician: certific rector.	o Be C	25. Was case referred to medical examiner?	Hospital: 1 Alpatient 2	ER/Outpatient 3	Other	eath (Check only one) Home 5 Residence	
of	nding Phys th. : After this s funeral di	H	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	
Division	al or Attending safter death. I Director: After din by the funer	ertification:	3 Suicide 6 Could not determined	De 29a Place of Injury - At he	ome, farm, street, fac fy)	tory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Nu tate)

To the Hospita within 24 hours To the Funeral completely filted

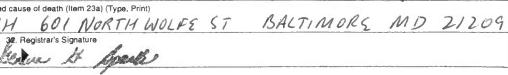
State Registrar

BOREK, PETER
31. Date filed (Month, Day, Year) JUL 2 7 2004

29b. Signature and title of certifier

BOREL (MD)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES-000

			1 _ For State	State of M	laryland / De	partment of Fertificate of		, ,	-5					
			Registrar 1. Decedent's Name (First, Middle, L	ast)	0.	ertificate of	Dealli	2. Date of Deat	eg. N6)	2 3 5 5				
	Physici		Scott A.	201/	Webster			Month July	Day Year 200	4 7:00A M				
	/Medic Examir		4a. Facility Name (If not institution, g.	ive street and number		4b. City. Town. o	or Location of Deat		4c. County of Dea					
	LAdilli	Ç.	7306 Honeywell L		,		hesda		Montgor					
	Funeral		Social Security Number 6.	Sex 7. A	ge (In yrs. last birthda	y) If Under 1 Year		8. Date of Birth	9. Bir	thplace (State or Foreign				
	Director		579-70-2324	1∭M 2□F	52 Yrs.	Months Days	Hours Min.	Jan. 31	, 1952 Was	hington DC				
	p ,		Usual Residence of Decedent 10a. State 10b. County		100 Cit. Town									
	shov	-	,		10c. City, Town or		-			10d. Inside City Limits 1 ☐ Yes 2√2 No				
	Ne M	ectc	Maryland Montgor	nery			nesda							
	filed within 72 hours atter death with the Maryland Hyglene. ther then "netural" or Items 23e or 28e-f show ont, the Medical Examinar must be notitied at	Funeral Director	10e. Street and Number 7306 Honeywell L	ane		10f. Zip Code 20	814	'	Og. Citizen of What Co United St	,				
	deat deat	ner	11. Marital Status	12. Was Deceden	t Ever in U.S.	J. Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame					
9	or Ite		1 Never Married 2 Married	1 Tes 2 X		1 ☐ Yes 2 ☒ No		to nican, etc.)	Black, White	e, etc. Nhite				
21215-0036	ural'.	d by	3 Widowed 4 Divorced	Year or Dates:										
15	"net	Completed	15. Decedent's (Specify only highest g		16a. Dec	edent's Usual Occup re kind of work done . DO NOT use retire	pation during most of wo	rking	16b. Kind of Business	Kind of Business/Industry				
12	within ene.	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	vailable)	u)		(Unavailat	10)				
	Hygied other	a l	17. Father's Name (First, Middle, Las	(1)	Conc	variable	18. Mother's Na	me (First, Middle, M	(Unavailable) Middle, Maiden Sumame)					
ylan	Mental Mental arked a	To B	Russel Edw	in W	lebster		Edith	Agu	Agusta Schoenerr					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23a or 28e-f show any injury or other treumatic event, the Madical Examinat must be notitied at once.		19a. Informant's Name/Relationship Maureen Webster			iling Address (Street Honeywe1			City or Town, State, 2					
	Heali Hem 2 tem 2		20a. Method of Disposition	/ WIIE	20b. Place of Dis	position (Name of		Date	20c. Location - City or					
<u>o</u> E	ages ent of t: If i			1 Burial 2 X Cremation 3 Removal from State 1 Donation 5 Other (Specify) 1 Removal from State Chesapeake Crematory 2004										
Baltimore,	mit. F partm sorter r injur		Six allure of Funer 4 Service Lie		-	22. Name and Addre	<u> </u>		Beltsvil	ie, m				
ä	Depar Impo any ir		A C	No.		933 Gist A	Ave., Sil	remation ver Sprin	Services	910				
	*		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nnlications that cause						Approximate Interval Between				
	Physician `		Immediate Cause (Final disease or condition		us Cell Ca					Onset and Death 1 year				
l,	/Medical Examiner		resulting in death)		s a consequence of):									
		70	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequence of):									
	nsit	nln	Cause (Disease or injury	200 10 (0. 00	a democracing only.									
o Î	execunation and ital-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	s a consequence of):									
8760	licate be executed physician and s the burial-transit	dical		d										
9	rtifica ng ph as th	Ned	IF FEMALE.											
Š	th ce tendii	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth		☐Ectopic pregnancy	,		23d. Date of del	•				
P.O. Box	that the death certifed by the attending detached for use as	by Physiclan/Me	1 Yes 2 No	4□Pregnant a 9□ Unknown	at time of death 5	Other (specify)			Month	Day Year				
	that the ed by detact	/ Ph	Part II. Other significant conditions	contributing to death I	but not resulting in the	underlying cause giv	ren in Part I.	23e. Did tob	acco use contribute to	the cause of death?				
Division of Vital Records,	The law requires that the death certifities has been signed by the attending page 2 should be detached for use as							1 ☐ Ye	s 2 No 3 Pro	obably 4 XUnknown				
000	awre	Completed						24a. Was ar		topsy findings available				
ž	ysicien: The lavis certificate has director, page 2	mo						autopsy perform 1 Yes 2	ned? death?	completion of cause of 2 No				
ţ	Physicien: this certifice ral director, p	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one						
<u> </u>	Physic this ce al dire	10	1 ☐ Yes 2 X No		ent 2 ER/Outpatr	ent 3 DOA Oth	er: 4 🗌 Nursing H	ome 5 X Reside	nce 6 Other (Spec	cify)				
ח	ding Ph h. After thi funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ay Year) Injury	Wor		28d. Describe ho	w injury occurred					
<u>S</u>	ten leal tor: the	cat	2 Accident investigation 3 Suicide 6 Could not	he -			Yes 2 No	00/ 1 // /01						
<u>></u>	or Attendate after death Director:	Certification:	4 ☐ Homicide determine	building, e	jury - At home, farm, s tc. (Specify)	treet, factory, office		City or Town,	eet and Number or Ru , State)	rai Houte Number,				
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier 1X Certifying P	hysician: To the best	t of my knowledge, dea	ath occurred at the tin	ne, date and place	, and due to the ca	use(s) and manner as ite and place, and due	stated.				
	the Lihin 24	Medical	- A A A A	and manner si	tated.	29c. Licens								
	5 1 × 5 1		29b. Signature and fifth of pertition		M	D21		29	od. Date signed <i>(Month</i> July 22,					
	15	4	20 Name and addition of	completed carries of	donth (Itam 22=) 7				-,,					
	1		30. Name and address of person who Peter Pushkas M				, Bethese	da, MD 2	0814					
	Sta	tė	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature									
	Registr	ar	JULZ	7 2004 🕨 /	arneva	& do	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 3.-Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 8:10 a M K. White July 2004 24 Betty /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson **EDENWALD** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Wales 1 ☐ M 2 💢 F Yrs 11. Director 221-26-1486 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. and of Heatth and Mental Hygiene. ant: If itsm 27 is marked other than "netural", or Items 23e or 28a-f show ary or other treumatic event, the Medical Executivit must be notified at 1 TYes 2 No Funeral Directo Maryland Baltimore Towson 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 800 Southerly Road 21286 Great Britain Was Decedent Ever in U.S. Armed Forces?

1 — Yes 2 (A) No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Records Secretary Public Health 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William White James ٩ Betty Kennard 19a. Informant's Name/Relationship (Type, Print) Power of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn R. Kramer Phoenix, Attorney 22 Glenberry Court Maryland 21131 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State Department of Importent: If its any injury or o Hilltop Service Corp. 7-27-2004 4 Donation 5 Other (Specify) Towson Marvland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Approximate Interval Between Onset and Death 23a. Parti. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mos /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by t lid be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 10 No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy page . performe 212 No 1 Yes 2 No this certificate To the Hospitel or Attending Physician: 26. Place of Death (Check only one, 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No Certification: To 1 Tyes 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fo 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) inpleted cause of death (Item 23a) (Type, Print) 30. Name and address of

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2004

			State of Maryland / Dep	eartment of Health and Mental Hygic eartificate of Death	
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death
	/Medie		Leroy Paul Wilder, Sr. 4a. Fecility Name (If not institution, give street and number)	July 2 4b. City. Town, or Location of Death	22 2004 5:00 P ^M 4c. County of Death
	Examir	ier	209 Bertram Circle	Glen Burnie	Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		
:da	Director		217-34-5633		
	e Marylar Ba-f show	ctor	10a. State 10b. County 10c. City, Town or L Glen Burn		10d. Inside City Limits 1 ☐ Yes ※☐ No
	h with th	al Dire	10e. Street and Number 209 Bertram Circle	10f. Zip Code 10g). Citizen of What Country? USA
036	be filed within 72 hours after death with the Maryland hat Hygiene. od other than "natural", or Itams 23e or 28e-f show event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1 Ven 2 Mar	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify: white
Baltimore, Maryland 21215-0036	within 72 ho lene. than "natur tha Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a kind of work done during most of working DO NDT use retired)	b. Kind of Business/Industry Self-employed
2	Hygie Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	Carpenter 18. Mother's Name (First, Middle, Ma.	iden Sumame)
an	m == 0 \$	To Be	George Washington Wilder Sr.	Margaret Wil	·
ary	should Mind Mind Mind Mind Mind Mind Mind Min	-		ing Address (Street and Number or Rural Route Number, C	
Ž	and 2 valith a		Mr. Leroy P. Wilder Jr. / son 7732	? Overhill Rd. Glen Burn:	ie MD 21060
ore	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre.	matory or other place)	c. Location - City or Town, State
Ë	t. Pag rtment rtant:		'4 Depation 5 Other (Specify) Cedar Hi	II comecory	rooklyn, MD
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic as Once.		21. Signature of Funeral Pervice Consee M01364 1	2. Name and Address of FacilitySingleton Fur Second Ave SW Glen Burnie	neral Home P.A. MD 21061
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a. Multiplication a. Due to (or as a consequence of):	Tery Disease	immedia te
	Examiner		Loronary Av	Tery Disease	1 Year
	D ===	Examiner	Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury		
_	le be executed ysician and e burial-transit	xam	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
760,	be essician buria	cal E	546 (6) 45 45 4 65 1564 55 160 61).		
687	w ~ 0		d		
Box	death certificate b e attending physic d tor use as the b	Completed by Physiclan/Med	1 Ves 2 No 4 Pregnant at time of death 5	☐Ectopic pregnancy	23d. Date of delivery Month Day Year
о. О.	that the de sed by the a detached t	hys	9 ☐ Unknown		
Vital Records,	equires that en signed i	ed by	Part II. Other significant conditions contributing to death but not resulting in the under the significant conditions are significant conditions. Type II.	Inderlying cause given in Part I. 23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
eco	ne ław require has been sig ge 2 should b	plet	Hyperthysion	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>~</u>	The page	Соп		performer 1 ☐ Yes 2 💆	1? death? No 1 Yes 2 No
Vita V	iclan sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death Check only one	
ot	Physician: The la r this certificate has ral director, page 2	2	1 ☐ Yes 2 ♣ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of Injury 28b. Time of		
o	th. : Afte	tlon	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	if 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	injury occurred
Division of	after death. I Director: After th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28f. Location (Stree City or Town, S	t and Number or Rural Route Number, itate)
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled birector: After this certificate has been signed by the attending phy completely tilled in by the tuneral director, page 2 should be detached for use as the	edical C	29a. Certifier (Check only one) 1 Certifying Physician. To the basis of examination and/or in and manner stated.	n occurred at the time, date and place, and due to the causivestigation, in my opinion, death occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
)	To t withi To tl	Ň	29b. Signature and title of certifier Onether Jonnes MD	29c. License number 29d. 7	Date signed (Month, Day, Year) 23 204
	0	9	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) F	ruin 110 2 120
1	Sta	te	Jonathan Forman MD 1406 B 31. Date filed (Month, Day, Year) 32. Registrar's Signature A		ANT TINE
	Registr	-	111 2 7 2004 Same	Sparke	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meryland Medical Center University of **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, You June 28, Birthplace (State or Foreign Country) Year) 1X M 2□ F none Director 2004 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
int: If item 27 Is markad other than "naturel", or Itams 23e or 28e-f show if of Health and Mental Hygiene.
If item 27 is marked other than "naturel", or Itams 23e or 28a-f show or other treumatic event, it we Medical Examines must be notified at 10a. State unk 10b. County 10c. City, Town or Location 10d. Inside City Limits unk unk Director 1 ☐ Yes 2 ☐ No 10e. Street and Number unk 10f. Zip Code 10g. Citizen of What Country? unk USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: 3 Widowed 4 Divorced black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kalia N. Jeffers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 S. Greene Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Importent: If eny injury or once. `4 □Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 micia Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on e adsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Persistent Pulmonary Hypertension Physician /Medical **Examiner** o (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 22 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) adora Wonode, ND 20061078 Jora Worlding 07/09/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Address 225. Greene Street, Rm NW568, Paltimore, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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		•	For State Registrar	State of Maryla	-	artmen rtificat			and M		giene Reg. No	104	23619
	Physici	an	Decedent's Name (First, Middle, Last) LITILIA	M	M	OLF				2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin		WILLIA 4a. Facility Name (If not institution, give st				Town, or	Location o	of Death	J24 .		الا من Death	8.20 bw
Н	LAdiiiii	E1	Snai Hospital st	- Bellmore		BI	how	~ (LIL				N/A
	Funeral Director		100-10-3322 A	7. Age (In yrs	i. last birthday) 7 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt FEB. 14	, 1 ⁹ 907	9. Birth Cou	place (State or Foreign Intry) GERMANY
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation							10d. Inside City Limits
	Many e-f sh	ctor	MD N/A		BALT	IMORE							1 XYes 2 No
	or 28	Directo	10e. Street and Number			10f. Zip	Code	0100			10g. Citizen	of What Cou	-
	ns 23s	Funerai	6400 APOLLO DRIVE	2. Was Decedent Ever in	U.S. 13.1	Was Deced	dent of Hi	2120		cify Yes or No	- 14.	Race - Ameri	USA can Indian
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-f show eumatic event, the Medical Examinational be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		lf Yes, spec 1 ☐ Yes		Specify:	, Puerto I	cify Yes or No Rican, etc.)		Black, White	
2-0	72 ho 'natur	eted	15. Decedent's Education (Specify only highest grade		16a. Dece	kind of wor	rk done a	lurina most	of workii	ng	16b. Kind o	of Business/Ir	ndustry
7	within ene. than '	Completed	Elementary/Secondary (0·12) 5+	College (1-4or 5+)	TEAC	DO NOT US HER	se retired,)		_	LINGU	ISTICS	/SCHOLAR
9	illed Hygir other	Be Co	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,			•
ylan	should be and Mental marked o	To B	JOSEPH		WOL			MAR					ENIGSHOFER
Baltimore, Maryland 21215-0036		8 1	JANE WOLF/ WIFE	e, Print)		_				- BALT	-		·
ore,	ges 1 and t of Health If Item 27 or other to		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Re		Place of Dispo cemetery, cres	sition (Nan	ne of ther place			ate	20c. Locati	on - City or T	own, State
Ē	permit. Pages Department of I Importent: If It eny Injury or o		* 4 □ Donation 5 □ Other (Specify)	CHE	EVRA AH.					/2004			OWN, MD
Ba	Depa Impo eny le		21. Signature of Funer (Service Licensee							LEVINS OAD - F			MD 21208
	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the dea e cause on each line.	ath. Do not ent	er the mod	le of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):		1:0	Rul	n				10 d.
	Po iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):		M I	1146					10 01.
	eath certificate be executed attending physicien and for use as the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):								
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တ		/Med	IF FEMALE:	c. If yes, outcome of pregi									
O. Box	0 0	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fe/ 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pr Other (sp					23d.	Date of deliv Month	ery Day Year
o, O	law requires that the de as been signed by the a 2 should be detached f	by Ph	Part II Other significant conditions cont	ributing to death but not re	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	obacco use o	ontribute to t	he cause of death?
ord	w require been sig should b	ted	Thenia							101	res 2□N	o 3 🗆 Prol	bably 4 Donknown
Vital Records,	The ate h	Completed								24a. Was autop perfor	rmed?	prior to co death?	opsy findings available impletion of cause of
/ita	Physician: The this certificate al director, peg	ВеС	25. Was case referred to medical examiner?						of Death	(Check only o			
ot	Physic this c	. To	1 Yes 2 Mo		ER/Outpatier			4 🗆 1901		ne 5 Resid			(y)
O	th: After fune	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	M	8c. Injury Work 1 ☐ \	:?` /es 2 □ l		.00. 003011001	iow injury oo	odirod .	
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	To the Hospitel within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my kr er: On the basis of examinand manner stated.	nowledge, death nation and/or in	occurred vestigation,	at the tim	e, date and pinion, deat	d place, a	and due to the ded at the time, d	cause(s) and date and plac	manner as s ce, and due t	stated. o the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	- 1			. License				29d. Date sig	gned (Month,	
)	1.		M W	1/5		R	52-	00	<u> </u>		July	25 2	00 Y
	V		30. Name and address of person who con Amera Ether.			Print)	الحال	+ B	the	ne			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign					· g		_		
	Registr	ar	JUL 2 7 2004	Canera	19	hora	1						

			1- For State of Maryland		artment of H			jiene leg. NG. () () /	. 23620
	Physici	20	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	/Medi		Mae Zook		U 01: T		July	23 200	4 HINSA M
4	Examir	ner	4a. Facility Name (If not institution, give street and number)		Balti	Location of Death	J	4c. County of I	N/A
	Funeral		Stella Maris At Mercy 5. Social Security Number 6. Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		219-14-1460 1 M 2 X 81	Yrs.	Months Days	Hours Min.	(Month, Day April	17.1923	Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	cation		- 252.45		10d. Inside City Limits
	Maryl f sho	tor		Baltim					1 ☐¥es 2 ☐ No
	r 28a	Funeral Director	10e. Street and Number		10f. Zip Code			l0g. Citizen of Wha	t Country?
	th wit	al D	600 Light Street Apt. 222		21	1230		USA	
	tems	nuel	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	3. 13. V	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spanic Origin)	ecify Yes or No- Rican, etc.)	14. Race - A	American Indian, Vhite, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give $\hat{\Lambda}$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1⊡Yes 21√2 No	Specify:		Specify: W	
21215-0036	2 hou	ted	15. Decedent's Education	16a. Decec	dent's Usual Occupa	ation		16b. Kind of Busin	
215	ithin 7 ie. ien "n iMed	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. l	NOT use retired	during most of worki)	ng		
	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28a-1 show ant, the Medical Examinat must be multified at		12		Cook	40.14.4.4.1	700		Industry
al	to be of	Be c	17. Father's Name (First, Middle, Last) Robert Doenges			18. Mother's Name		•	
Maryland	should be fand Mental Band Mental Bandwed of	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a	LLLLL and Number or Rura	an Frank U Route Numbel		te, Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Departnent of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating the radiified at ance.		Carol Cross / Daughter			Court Mil			
Baltimore,	Pages 1		20a Method of Disposition 20b. Pt	ace of Dispos	sition (Name of natory or other place	e) [Date	20c. Location - City	
Ē	t. Pag tment tant: ijury o		`4 □ Donation 5 □ Other (Specify) Me		ematory 1		704	Baltimor	e, MO
Bal	permit. Departr Importa any injugance.		21. Signature of Funeral Service (Mensee	C C	. Name and Addres	Society (Cick Road	Of Maryl	and Inc.	
			Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death	. Do not ent	99 Freder or the mode of dying	cick Road g, such as cardiac o	Baltimo or respiratory arr	ore, Mary	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1 -					Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	ence of):	5 CW	nur			
	Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ						
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9	ing ph	Med	IF FEMALE:						
Вох	eath certific attending p	lan/	23b. Was decedent pregnant 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal	death 3□	Ectopic pregnancy			23d. Date of Month	delivery Day Year
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rds	w require been sig should b						1 Ye	as 2 □ No 3 □] Probably 4 Unknown
Records,	e law re has be je 2 sh	Completed					24a. Was a autops	v 🦯 prior	autopsy findings available to completion of cause of
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Vital	Phyaician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Tyes 2 Tyo Hospital: 1 Tyonatient 2 TE		Othe	26. Place of Death			- L
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ion	ttending F death. ctor: After y the funer	atlo	2 Accident investigation	Injury		r? res 2 □ No			
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Ω	pital o		29a. Certifier Certifying Physician: To the best of my know						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	on and/or inv	restigation, in my op	oinion, death occurre	and at the time, di	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License		2	9d. Date signed (M	1
	10		> God Ilm j m		D 20	0854		7/23	,12004
	· ·		30. Name and address of person who completed cause of death (Item	301	St, Paul	PI	Bathers	7 2120	3
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	ILO I	22.41				
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			For	State of Marylan	d / Dep	artment of H	ealth and Mo	ental Hyg	iene	
			State Registrar		Ce	ertificate of L			eg. NB. () () Lj	23621
	Physicia		1. Decedent's Name (First, Middle, Last)	2/		_		2. Date of Deat Month	Day Year	3. Time of Death
	/Medic	al -	CHARLES K		AN		Location of Death	7	4c. County of Death	0326AM
	Examin	er	4a. Facility Name (If not institution, give s	reet and number)	HEI	2 /2//	Call Col		50110	AA-
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	year) 9. Birth	place (State or Foreign
	Director		236-70-9960 ¹⁰	M 2□F 57	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 10-25-4	46 ELK	ÏNS, WV
	pu k	-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or	Location				10d. Inside City Limits
	daryla f sho	ō	WV TUCKER		THOM					XXes 2 □ No
	r 28e-	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	h with	aiD	PO BOX 312			2629	2	,	USA	
	ams ams	Funerai		2. Was Decedent Ever in U Armed Forces? XX es 2 ☐ No	.S. 13	I. Was Decedent of H	ispanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	MXYes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: WH	ITE
Ş	n 72 hours after death with the Maryland "naturel", or Itams 23a or 28e-f show safted Examinat must be notified at		15. Decedent's Educ		16a. Dec	edent's Usual Occup	ation		16b. Kind of Business/I	ndustry
75	C 2 20	piet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	`life	re kind of work done of DO NOT use retired	1)	ng		
7		Completed	12		TRU	CK DRIVE			TRUCKING	
Maryland 21215-0036	be find H	Be	17. Father's Name (First, Middle, Last) CHARLES K. BLA	ND. SR.			18. Mother's Name		Maiden Sumame) ISE SINES	
3	d 2 should th and Men 7 is marke treumetic	ပ္	19a. Informant's Name/Relationship (Type		19b. Ma	iling Address (Street	· · · · · · · · · · · · · · · · · · ·		, City or Town, State, Z	ip Code)
Ma	tre tre		GLORIA BLAND /			BOX 312,			6292	
	s 1 and of Healt itsm 2 other		20a. Method of Disposition		Place of Dis	position (Name of rematory or other place		ate	20c. Location - City or	Town, State
E	Pages nent of ant: If it		1 🖾 Burial 2 ☐ Cremation 3 ☐ Ro • 4 ☐ Donation 5 ☐ Other (Specify)	ROS	SE HI	LL CEMET	ERY 7/10	0/04 1	THOMAS, W	V
Baltimore,	permit. Pag Department Important: any injury c		21. Signature of Firreral Service License		INC.					
_	40 E # 9	_	23a. Part1. Enter the disease, or compli	nxee	h Donate	PO BOX 1			26260	Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.				Wascell		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec			7	400		
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9	leath certifica attending ph I for use as th	Physician/Medical	IF FEMALE:							
Box	ath ce	lan/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	al death	B Ectopic pregnancy	,		23d. Date of deli Month	very Day Year
0.	that the de led by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	eatn :	o □ Other (<i>specily)</i> _				
٥.	es that t igned by be deta	by Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
Records,	w requires been sig should by							1 □ Y€	es 2□No 3□Pro	bably 4 Unknown
900	ie law requ has been ge 2 shouli	plet						24a. Was a autops	v prior to c	topsy findings available ompletion of cause of
E.		Completed						perform 1 Tes	med? death? ≥ENo 1 ☐ Yes	2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	,	iont 3 DOA Oth	26. Place of Death			
of	Phys rthis ral dir	2	↑ Yes 2 No	28a. Date of Injury (Month, Day Year)	ER/Outpat 28b. Time	INIT 3 DOV	4 Nuising Hor		ence 6 Other (Spec ow injury occurred	sify)
	Attanding I ir death. actor: After by the funer	ation	Natural 5 Pending investigation	(Month, Day Year)	Injur		k? Yes 2 □No			
Division	To tha Hospitel or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: Atter th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At It building, etc. (Special	ome, farm,	street, factory, office	2	28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,
0	oitel or urs afte aral Dir		Continue Physics	ician Table has a familia		ash annual at the fir	no data and slage.	and due to the a	0(a) and manner as	stated
	To the Hospitel within 24 hours a To the Funeral I completely filled	edicai		sician: To the best of my kn ner: On the basis of examin- and manner stated.						
	Fo the vithin To the Somple	Me	29b. Signature and title of certifier	- 10		29c. Licens	e number	2	9d. Date signed (Manti	n, Day, Year)
)			Danel Ran	es melle		1+2	6154		7/14/0	4
	5		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Typ	e, Print)	Link	12/11	W PIAN S	100
			31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature (C	wolff	CNESIN (14/1/4	MUNI 2	1330
	Sta Regist		31. Date filed (<i>Month, Day, Feat)</i>	Genetica	6	boate				

			For	State of Maryland / Department		Mental Hygie	ene	
			1 - State Registrar	Ce	rtificate of Death	Reg.	. Nø. () ()	23622
	Physici	ian	1. Decedent's Name (First, Middle, Last			2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal		SIE BAllard	T	07	11 04	12:05 P.M
	Examir	ner	4a. Facility Name (If not institution, give 3538 Freedom		4b. City, Town, or Location of Dea	ith	4c. County of Death	
	F		5. Social Security Number 6. Se	7. Age (In vrs. last birthday)	If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	Some/s	
	Funeral Director		215-05-5429	M 2□F 88 Yrs.	Months Days Hours Min		ear) Coun	place (State or Foreign htry)
	p.		Usual Residence of Decedent					
	anylar	_	10a. State 10b. County	10c. City, Town or Lo			1	0d. Inside City Limits
	he M 18a-f	ecto	301	nerset Crist				1 ☐ Yes 2 ₹No
	a or 2	Funeral Director	3538 Threedom	In ON	10f. Zip Code 218(7	10g.	Citizen of What Coun	try?
	leath	era	11. Marital Status			Specify Yes or No-	14. Race - Americ	Can Indian
ပ္	or Itar	E	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White,	
8	ral', o	b	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ ¶a, Specify:		Specify: B	ack
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "natural" or Itams 23e or 28e-f show event, the Mudical Exam or must be rutilled at	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (Give	dent's Usual Occupation kind of work done during most of wo	orking 16t	b. Kind of Business/Inc	Justry
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	filed with Hygiene. Ither ther		17. Father's Name (First, Middle, Last)			me (First, Middle, Mai	Constru	CTIO ~
an	ld be ental kad o	To Be	James Bal	lard	HARR:		Magd	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	-	19a. Informant's Name/Relationship (T)	rpe, Print) 19b. Maili	ng Address (Street and Number or R		ity or Town, State, Zip	Code)
	12 mg		MERLEN F. Sutton	- Daughter 3538	Fredom town	Road Cr	is field 1	1D 21817
ore	ges 1 at the true or oth	1 3	20a. Method of Disposition 1. ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Dispo			. Location - City or To	
Ĕ	nit. Pages artment of ortant: If Its injury or o		`4 □Donation 5 □ Other (Specify)	Asbury	Cemetery 7-1	7-04 (risfield,	MD
Baltimore,	permit. Pages 1 at Department of Hea Important: If Item any injury or othe once.		21. Signature of Funeral Service Licens	90	Name and Address of Facility	D .1		
	⊈ ∪ ≥ ≅ o		Huthing E. a	en Ey. 3	1	truneral to	21817	
			shock, or heart fajfure. List only o		1.0	c or respiratory arrest,	-	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ners Di	SCASE		pars
В	Examiner			Due to (or as a consequence of):				
		le.	if any leading to immediate	Due to (or as a consequence of):				
	cuted od ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events					
Ö,	ate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
8760,	ate b hysic the b	dicai		1				
9	eath certific attending p	Me	IF FEMALE:	20. If yes, outcome of programmy				
Вох	atten for us	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ⊡ No 9 ☐ Unknown	9 Unknown	Other (specify)			
Δ.	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	by Pt	Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
Records,	quire;	q pa				1 Tes	2 No 3 Proba	ably 4 Unknown
000	aw requisite been 2 should	Completed				24a. Was an	24b. Were autop	osy findings available
Ä	The lay	mo:				autopsy performed	death?	pletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?		26. Place of De	ath Check only one)	10,103	20110
of V	Physic this ca al dire	2	1 ☐ Yes 2 ☐ No	lospital: 1 Inpatient 2 ER/Outpatien	it 3 DOA Other: 4 Nursing	dome 5 Residence	6 □Other (Specify))
	fter ne	iuo	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how is		
Sic	Attending it death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	200 Place of lawn. At home form	M 1 ☐ Yes 2 ☐ No	20t Landing (Chin		
Division	P it o	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	City or Town, St	t and Number or Rural tate)	Houte Number,
	id is in it		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, death	occurred at the time, date and place	and due to the cause	a(s) and manner as sta	ated
	A Fu	edical	(Check only 2 Medical Exami	ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occi	urred at the time, date	and place, and due to	the cause(s)
	To the Hos within 24 ho To the Func completely f	ĕ	29b. Signature and title of certifier	4.	29c. License number	29d.	Date signed (Month, D	ay, Year)
			· 6/Wett	mo (1)	DSTOC	5	2/ 14/0	4
			12. Am/ C	mpleted cause of death (Item 23a) (Type,	Brint) Regling Co	B (500)	7	6.5
			31. Date filed (Month, Day, Year)	32. Proistrar's Signature	Mighingy C.	rustald,	2000 20	0()
	Sta	te	IIII 1 A 20					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						State) IVIA	i yiariu / i	•	rtificate		Death		Reg. No.	004	,	23623
	Physicia		1. Decedent's Nam	ne (First, Midd			n Bri	.dgwater					2. Dete of D Month June 29	Day	Yea	r	3. Time of Death
)	/Medica Examine		4a Fecility Neme (If not institution							4	lb. City, Town, or			County of De	eth	2:35 PM
			25738 S	Southwell	l Lan	e						Hollywood		St	t. Mary	· s	
	Funeral Director		5. Social Security N 410-60-270		6. Sex	M 2□F	7. Age	(In yrs. lest bii 65	thday) Yrs.	If Under Months		If Under 24 Hrs Hours Min.				lirthpla Co <i>untr</i> Texa	nce <i>(State or Foreign</i> y) as
	wor.	1	Usual Residence o 10a. State	f Decedent 10b. County	,			10c. City, Tow	n or Lo	cation						10	d. Inside City Limits
	e Mer	to	Texas	Tarrar	ıt			North R	lichl	and Hi	11s						1 ☐ Yes 2∏ No
	with th	i Director	10e. Street end Nu 7516 No	mber orth Rich	oland	Roulev	ard			10f. Zip (en of What o	Countr	y?
)ZO	parmit. Peges 1 and 2 should be filed within 72 hours after death with the Merylend Department of Haaith and Mental Hygiena. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Merital Status 1 Never Marr 3 Widowed	ried 2□ Mai	ried	12. Was Dec Armed Fr 1 1 Yes If Yes, Gi Year or D	cedent Evorces?				ent of H fy Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0- 14	4. Race - An Black, Wh		c.
Maryland Z1Z13-00Z0	within 72 hou ana. than *natura	Be Completed	(Spec	15. Deceder cify only higher ondary (0-12)	nt's Educ est grade	cetion completed) College ()	life. E	lent's Usual kind of work DO NOT use	e retired	•	rking		d of Busines		stry
7	filed v Hygle ther t	ပ္ရွိ -	17. Father's Neme	(First, Middle	Last)			EL	ecti	OHIES .	reciii	18. Mother's Na	me (First, Middle		ctronio	cs_	
	d be ental	To Be		Gilbert		dgwater							ne Leiper	,	,		
	nd M meri	۱	19a. Informant's N					196	. Mailin	g Address	(Street	and Number or Ri		ber, City or	Town, State	, Zip C	Code)
Ž	alth a 27 la r tra		Karen M	cCleaf/L	augh	ter		2	5738	South	we11	Lane, Holi	lywood, M	2063	6		
painmore,	Peges 1 and of Hanner: if Item		20a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	Cremation		emoval from	State	20b. Place o cemete Metropo	ry, crem	natory or oth	her plac		Date July 1, 2004		ation - City o andria,		
	parmit. Departrimporta		21. Signature of Fu	uneral Survice	\supset	men	^		M	lattin	igle	ss of Facility y-Gardin 270 Leon			ome, I		•
	Physician /Medical Examiner		23a. Part1. Enter t shock, or hea Immediete Cause disease or condition resulting in deeth)	(Final	r compli l only on a			ne death. Do ebral Me			of dyin	g, such as cardia	c or respiratory a	arrest,			Approximate Interval Between Onset and Death H Months
		- E						ue to (or es a								1	
00/00	ifficate be axecuted g physician and as the burial-transit	8	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	enditions, nmediate ending injury s Last		. <u>Carc</u>	D	ue to (or es e	consequ	uence of):						6	+ Months
You	th cert endin r use	ary.			d											<u>i </u>	
5.	v requires that the death certifications is to be not signed by the attending should be detached for use as	P Š	Part II. Other signif	ficent conditi	ons con	tributing to d	eath but	not resulting in	n the un	nderlying ca	use give	en in Part I.		tobacco us			he cause of death?
ַ	law requires as been sign as should be	Completed by											24a. Wes	an autopsy ormed?	y 24b	avail	autopsy findings able prior to pletion of cause eath?
_ (ne nate h	5											40	Yus 2 💢	No	10	Yes 2□ No
AITA	Physician: The law r this cartificate has b aral director, page 2 s	To Be	25. Was case referexaminer? 1 ☐ Yes 2 ☑ 27. Menner of Deet	No	+	28a. Date	of Injury		Time of		Other	4 Li Nursing F	ath (Check only lome 5 - Res 28d. Describe	idence 6 §		ecify)∏	Daughter's Residence
DIVISION	To the hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this cartific completaly filled in by the funeral director,	Certification:	1 ⊠Netural 2 □ Accident 3 □ Suicide 4 □ Homicide	5 Pendii investi 6 Could detern	gation not be	28e. Place		(specify)	njury rm, stre	М	1 🗆 '	(? Yes 2 □ No		Street and I wn, Stete)	Number or F	Rural F	Route Number,
-	• Hospital • 124 hours • Funeral letaly filled	Medical C	29a. Certifier (Check only	1 Certifyic			asis of e	xemination an				e, date and place pinion, death occu					
	within To the	M	29b. Signature and	Athe of certifie)[/	\sim			29c.	License	number		29d. Date s	signed (Mor	nth, Da	ıy, Year)
	SAO		30. Name and eddr	ulfo	who on	moleted cour	Se of dea	th (Item 22c)	Type		1502	7		June 30	2004		
	(0		1/								nics	ville, MD	20659				
2	State Registra		31. Date filed (Mon		1			s Signature				2,					

			For State	State of Maryland		artment of		ind Me	ental Hy	-	1	00601
			Registrar 1. Decedent's Name (First, Middle, Las.	?)	007	incate c	Death		2. Date of De	Reg. No.	704	3. Time of Death
	Physici			nces Brown				.1	Month June 2	9 Day	Year 004	9:47 P M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Tow	n, or Location o				County of Death	1 2017 2
	CAUTIII		St. Mary's Hospi			Leon	ardtown			S	St. Mary	s
	Funeral		Social Security Number 6. Security Number	7. Age (In yrs. Ia		If Under 1 Ye		24 Hrs. 8	8. Date of Bi	rth ay, Year)	9. Birthp	place (State or Foreign htry) ington, D.
	Director		5/9-84-2938	76	Yrs.		,	A	April	24,19	928 Wash	ington, D.
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					1	IOd. Inside City Limits
	Mary	ō	MD St. Mar	v's Le	xinot	on Park						1 ☐ Yes 2 XNo
	28a	Director	10e. Street and Number	<i>y</i> 5		10f. Zip Cod				10g. Citiz	zen of What Cour	ntry?
	tiled within 72 hours after death with the Maryland Hygiene. Hygiene "natural", or iteme 23a or 28a-f show ent, the Macinal Expediter must be motified at	0	45770 Bee Creek	Lane		20	653			Uni	ted Stat	tes
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent	of Hispanic Orig Cuban, Mexican	gin? (Spec	ity Yes or Ni	0-	14. Race - Americ Black, White,	
2	or ite	/Fu	1 ☐ Never Married 2 🕅 Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 □ Yes 2 X □		, , , , , , , , , , , , , , , , , , , ,				ite
Š	urai',	d by	3 Widowed 4 Divorced	Year or Dates:						101 15		
5	n 72	lete	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Oc kind of work do DO NOT use re	ne during most	of working	g	16b. Kir	nd of Business/In	dustry
7	within Bne. than	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		maker	,			70	wn Home	
2	s 1 and 2 should be filed withir if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Ma	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name ((First, Middle	, Maiden	Sumame)	
0	lid be lental rked o	To B	John Niess				Mari	an Ma	ann			
<u></u>	should land Men and Men marke		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Str	eet and Numbe	r or Rural	Route Numb	oer, City or	r Town, State, Zip	Code)
2	Health a tem 27 is other train	- 0	Thomas Francis I	Brown (HUSBAND)	457	70 Bee	Creek L	ane I	Lexing	ton I	Park, MD	20653
ב כ	of He of He fiten r oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	ra	ace of Dispo metery, crer	sition (Name of natory or other	f place) July	7 2, Da	2004	20c. Lo	cation - City or To	own, Stete
	Pag ment ant: I ury o		'4 □Donation 5 □Other (Specify				ls Crem				rlotte H	
Dalithino	permit. Pages 1 an Department of Heal Important: if item 2 any njury or other once.		21. Signature of Funeral Service Lickn	_ David H. Go								me, P.A.
	205 g		1 elyjor	MO 10	-					The second secon	wn, Mary	land 20650
			23a. P.v. 1. Enter the disease, or comp ck, or heart fally e. Lis. only	to management the	all .		and the same of	Q-	respiratory a	arrøst,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Fi al disease or condition resulting in death)	· ventricul	en C	mm	JAnn	rer			V	nimits
	/Medical Examiner		To Sulling III doutiny	a. Venneud Due to (or as a consequence of Carana)	ence of):	-0	dine	11				9:11/10-
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ		erry o	non					1 years
	nted Insit	E I	cause. Enter Underlying Cause (Diseese or injury		,							
•	cate be executed ohysician and the burial-transit	Examiner	that initiated avents resulting in death) Last	C. Due to (or as a consequ	ence of):							
0000	ysicia e bur	dicai	(d								
8	tifical ng ph as th	ledi	15.55.44.5									
5	The law requires that the death certifics to has been signed by the attending phage 2 should be detached for use as to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		Ectopic pregna	ancv			2	23d. Date of delive	The second second
	e dea he at	sici	in the past 12 months?	4 Pregnant at time of de 9 Unknown	ath 5□	Other (specify)				Month	Day Year
	d by t	Phy	9 Unknown Part II. Other significant conditions or		Min or in the country	- d b d	anna ia Bad I		220 Did	tahanan u	an anatributa ta th	he cause of death?
ń	signe l be d	þ	O A A A A STAD	11 Clark Larles	iting in the d	nuerlying cause	given in Fait i.			Yes 2	-	pably 4 Unknown
cords,	requ	Completed	- Coveyiocoo v	10000								
ב ט	e law has t	idu		V					24a. Was		24b. Were auto prior to co death?	psy findings available mpletion of cause of
	ilcian: The lav certificate has rector, page 2								1 Yes	212 No	1 ☐ Yes	2 No
5	sicial certif recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	D/O-1		Other		(Check only			
5	Phys rr this aral dir	To :	27. Manner of Death	28a. Date of Injury	R/Outpatier 28b. Time of	I SU DOA I	njury at Work?		e 5 Hes Bd. Describe		Other (Specify occurred	n
5	ding th. : Afte	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Work? 1 □ Yøs 2 □ N	No				
2	Atter r dea ector by the	ertification;	3 Suicide 6 Could not be 4 Homicide determined	289. Place of injury - At not	ne, farm, str	eet, factory, off	ice	28			d Number or Rura	Il Route Number,
5	el or s afte il Dir	Cert	4 Nomicide	building, etc. (Specify,	,				City of 10	wn, State)	/	
	ospite hours uners ly fille		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	vledge, deatl	h occurrad at th	e time, date and	d place, an	nd due to the	cause(s)	and manner as st	tated.
	To the Hospitel or Attending Physician: The la within 24 brouts after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	one)	iner: On the basis of examinati and manner stated.	on and/or in	vestigation, in n	ny opinion, deat	ii occuff#0	u at the time,			
	To t To t	Σ	29b. Signature and title of certifier	,		29c. Lic	ense number	1001			e signed (Month,	
			PIIIX			()	1455	UY		Jul	Ly 1, 200)4
/	001	-	30. Name and addless of person who	completed cause of death (Item				י גם	ah	Ma	-1 1 00	657

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

B.K.S JULLIAN BEASE II

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لطال	LIAN BE	ASI	For State Registrar	State of M	Marylan		artmen			and M	•	giene Rag. N.	nni.	22005
			Decedent's Name (First, Midd)	le, Last)							2. Date of De			3. Time of Death
	Physici /Medic		Julian Napol								JULY	5,	2004	0230 A M
	Examin	er	4a. Facility Name (If not institutio 4839 CLAYBU		ər)				Location o			4c.	County of Death	
_	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. I	ast birthday)		1 Year Days	If Under		8. Date of Birt (Month, Da	h v Yearl	9. Birth	place (State or Foreign
L	Director		213-94-7428	1 X M 2 □ F	24	Yrs.	WICHTIS	Days	riours	WIII I,	8/18/		MD	
	fand ow		Usual Residence of Decedent 10a. State 10b. County	/	10c. City	, Town or Lo	cation		-					10d. Inside City Limits
	a-f sh	ctor	DE Suss	ex	Sea	ford								1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number 139 Pinecove	Circlo			10f. Zip	Code 9973				10g. Citiz	en of What Cou	ntry?
	ns 236	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13.1				gin? (Spe	ecify Yes or No		4. Race - Ameri	can Indian,
ထွ	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importents if item 27 le marked other than "natural", or items 23e or 28e-f show amy nighty or other traumatic event, the Medical Eracifical entail the notified at ODGS.	Fun	Never Married 2 ☐ Mar	Armed Force	s?	ì	f Yes, sped 1 ☐ Yes		Specify:	, Puerto	ecify Yes or No Rican, etc.)		Black, White,	etc.
Maryland 21215-0036	hours ural',	d by	3 ☐ Widowed 4 ☐ Divorced		s:							2	Specify: Bl	
5	in 72 n "nat	Completed	(Specify only highe	nt's Education est grade completed)	.5.)	16a. Deced (Give life. i	kind of wo DO NOT u	al Occupa rk done d se retired,	ition luring most)	t of work	ing	16b. Kir	nd of Business/In	dustry
212	d with	Com	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Sa	alesi	nan					partment	Store
and	be file	Be	17. Father's Name (First, Middle,								(First, Middle,	Maiden 3	Sumame)	
2	should ind Men marke umatic	ဥ	Julian Napo		e Sr.		na Address		Mary			ar. City or	Town, State, Zip	Code)
	and 2 sealth ar n 27 le		Susan Bease-	Grandmoth	er		•						, DE 19	· ·
Baltimore,	Pages 1 and of He sout: If item arry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Sta	20b. Pi	lace of Dispo emetery, crer	sition (Nar natory or o	ne of ther place	9)	[Date	20c. Loc	eation - City or To	own, State
<u>=</u>	pemit. Page Department Importent: If any injury or once		' 4 □ Donation 5 □ Other (\$ 21. Signature of Funeral Service	Specify)	Wh	atcoa	at Ce		-		0/04	Dov	er, DE	
Ba	Deparation of the sany once		Dry X	Prince	,	0.000					Dover,	DE		
	Maria		23a. rtl. Enter the disease, o shick, or heart failure. Lis	r complications that cause t only one cause on each	sed the death							rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Mu	ltip	le g	usl	ret	WO	nucls			Onset and Death
	/Medical Examiner		rosaking in deathy	Due to (or	as a consequ	ience of):								
	*	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	uence of):								
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequ	ience of):								
8760,	sician burial	dicai E	,	1	as a consequ	delice oi).								
9	tificate ig physas the	ledic		d										
Вох	death certifica attending ph d for use as t	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3]Ectopic pi					2	3d. Date of delive	ery Day Year
P.O.	that the death cert ed by the attendin detached tor use	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnan 9☐ Unknown	tat time of de	eath 5	Other (sp	ecify)						24,
<u>ري</u>	The law requires that the death certificate be executed ate been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant conditi	ions contributing to deat	n but not resu	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did to	bacco us	se contribute lo ti	he cause of death?
ğ	w require been sig should b										1 🗆 \	/es 2. <mark>X</mark>	No 3□Prot	pably 4 Dunknown
Division of Vital Records,	e law r has be je 2 sh	Completed									24a. Was autop		prior to co	ppsy findings available mpletion of cause of
<u></u>	vician: Th certiticate rector, pag	e Co	25. Was case referred to medical						26 Piaco	of Doath		2 🗆 No	death? 1 X Yes	2 🗆 No
Ž	Physicie this cert al direct	To B	examiner? 1X Yes 2 □ No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatier	nt 3□ DC	Othe					Other (Specif	y) AT SCENE
o u	ing Pt		27. Manner of Death 1 Natural 5 Pendi		Day Year)	28b. Time of Injury	A 2	28c. Injury Work	at		28d. Describe h	now injury	occurred	
ISIC	or Attending Physician: after death. Director: After this certilici in by the funeral director, in	ficat	3 ☐ Suicide 6 ☐ Could	not be 390 Place of		Foul 2:		1 🗆 \	/es 2 X		28f. Location (S	Street and	Number or Rura	al Route Number,
<u>S</u>	s after of Dire	Certification:	4 Homicide determ	building,	etc. (Specify	"A+	hon	re			4839 clu		Bactimo	re Gity, MD
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funerel Director: After this certilicate has completely illed in by the funeral director, page 2	edical		ng Physician: To the be I Examiner: On the basi and manner	s of examinal									
	To the within 2 To the complet	Me	29b. Signature and title of certific	er			290	C. License				290. Date	signed (Month,	
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			30. Name and address of person	who completed cause of the AU				æet,	Balt	timo	re, Mar	yland	1 21201	
	Sta		31. Date filed (Month, Day, Year) 32. Reg	strar's Signa									
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2004 JULY 23, **Physician** JOYCEMAE IRENE COOK 9:30 AM /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CARROLL WESTMINSTER 2642 LITTLESTOWN PIKE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye JULY 24, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 1, Year) 1929 **Funeral** Days Hours 1 □ M 3 □ F MARYLAND 74 Director 213-24-9231 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be radiified at or Items 23a or 28a-f ahow 1X Yes 2 No CARROLL WESTMINSTER Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 21157 17 KEMPER AVENUE Funerai 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 Y Yo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE à ₩Widowed 4 Divorced Be Compieted 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSING HOME LICENSED PRACTICAL NURSE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HENNIE VIOLA HAINES WILLIAM FREDERICK BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JUANITA M. VANSCHEETZ/DAUGHTER 6911 RUNIK PLACE N REYNOLDSBURG, OH 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State LAKEVIEW MEMORIAL PARK 7/27/2004 SYKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Funeral Service Licensee 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. R 91 WILLIS STREET, WESTMINSTER, MD 21157 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 Immediate Cause (Final disease or condition resulting in death) **Physician** Syea /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) P.O. Box 68760 Physician/Medicai use as the IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month ρ Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 3 ☐ Probably 4 ☐ tonknown 2 🗆 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 🕒 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) SONS 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannes of Death 28b. Time of Injury 1 🖃 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the th 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2004 D 5203T 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINU T. CHACKO M.D. 291 STONER AVENUE, WESTMINSTER, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

		For State Registrar	State of	Marylan		artment rtificate				Mental Hy	giene	nnı	23627
		1. Decedent's Name (First, Middle,	Last)							2. Date of De	ath	U I S	3. Time of Death
Physici /Media		Josephine Theresa	Cusic							July 14	Day 20)04 Year	3:30 P.
Examir		4a. Fecility Name (If not institution,	_	ber)		4b. City, 1	Town, or	Location	of Death		4c. C	ounty of Death	1
		24718 Half Pone				Holly					_	. Mary's	
Funeral Director		577-32-6262	5. Sex 7 1 □ M 2 ☑ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bin (Month, Da October	y, Year)	9. Birth Cod Mary	nplace (State or Foreig Untry) land
and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limit
Mary f sh	to	Maryland St. Mar	v's	Ho11	Lywood								1 ☐ Yes 2 🔀 N
n the	Director	10e. Street and Number	· -		J	10f. Zip	Code			T	10g. Citize	en of What Cou	untry?
th wit	ai D	24718 Half Pone Poi	nt Road			2063	36					USA	
d within 72 hours after death with the Maryland sleep, then "natural", or Itama 23a or 28a-f show then "natural", or Itama 23a or 28a-f show the Madical Examinating and the motified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		I. Race - Amer Black, White Specify: Whi	, etc.
2 hor	ted	15. Decedent's	Education	~	16a. Dece	dent's Usua	Occupa	tion			16b. Kind	of Business/li	ndustry
thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	4or 5+)	life.	kind of won DO NOT us	e retired,	uring mos	t or work	ing			
	Con	12			Busine	ss Owne	er				Plumb:		
uld be filed fental Hyg rked othal	Be	17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Nam	e (First, Middle,	Maiden S	umame)	
should band Ments s marked	2	Joseph NMN Alvey	n (Time Print)		105 14-16-	A 44	(5)			1 Thompso			
d 2 shouth and M 7 is martraumat		19a. Informant's Name/Relationsh	, , , , ,							al Route Numbe			ip Code)
क व व है		Stephanie L. Abell/I	Daugnter	20b. P	lace of Dispo	sition (Nam	e of			, Marylano Date		o ation - City or T	own State
Dermit. Pages 1 are Department of Heal mportant: If itam any Injury or othe page.		1XXBurial 2 ☐ Cremation		tate c	emetery, crer John 's	natory or ot	her place		1117 1	9,2004		wood, Mai	
artme ortani Injury		 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L. 		50.		. Name and				29,2004	потту	wood, Mai	ryrand
permit. Pages 1 Department of H Important: If its any Injury or ot once.		12/	in ou	_					•	eral Home own, Mary	P.A,	00650	
		23a. Part 1. Enter the disease, or o	omplications that car	used the death								20030	Approximate
Physician /Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)		or as a consequence of the conse	Mar	1 A	bro	513					Interval Between Onset and Death
Examiner			Due to (o	r as a consequence	uence of):		c ++	tont	5				
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that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		th 2 Fetal nt at time of de	Ideath 3	Ectopic pre Other (spe					23	d. Date of deliv Month	rery Day Year
hat hat bd b		Part II. Other significant condition	s contributing to dea	th but not rest	ulting in the ur	nderlying ca	use give	n in Part I.	,	23e. Did to	bacco use	contribute to t	the cause of death?
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law requires that as been signed b	Completed	aortic an	· Maka	,		,		/		24a. Was	an	24b. Were auto	opsy findings available
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an: rtifica for, p	O	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes	2 No	1 🗌 Yes	2No
Physician: this certific	To B	examiner? 1 □ Yes 2▼No	Hospital: 1 🗆 Inj	oatient 2	ER/Outpatien	t 3 🗆 DO	Othe	~	rsing Ho			☐Other (Speci	fv)
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ttandir death. ctor: Ai	atle	2 Accident investiga	ition		,,	М		es 2 🗆 1	No				
Il or Attand after death Director: ,	Certification:	3 Suicide 6 Could no 4 Homicide determin	280. Place 0	f Injury - At ho g, etc. (<i>Specif</i>)	ome, farm, str	eet, factory,	office			28f. Location (S City or Tow		Number or Run	al Route Number,
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To the Hospital or Attending within 24 hours atterded within 24 hours atterded to To the Funeral Director. After completely filled in by the fune	edical	29a. Certifier Certifying (Check only one)	Physician: To the b xaminar: On the bas and manne	is of examinal	wledge, death tion and/or inv	occurred a restigation,	t the time in my op	e, date an inion, deat	d place, th occurr	and due to the ored at the time, or	ause(s) ar date and pl	nd manner as s ace, and due t	stated. o the cause(s)
omple	Me	29b. Signature and title of certifier			_		License					signed (Month,	
->-0) (Vi~	atten	dins	_	1	000	556	182	_	7	-1161	04
		30. Name and address of person w		of death (Item		Print)				50,1205		2	
		Thomas M.	Wilkinson	MO,	23415	Thr	re 1	10 tch	nd	5014205	20	alifirn	ia MD
Sta	tę	31. Date filed (Month, Day, Year)	32 Rec	gistrar's Signa	bre do	W							
Registr	ar	JUL 16	2004	Mand S.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2004 8:15 P Ju1y Florence Elizabeth Coffren /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) **Funeral** Months 1 □ M 2 X F 87 3, Washington, D.C Director 579-03-0263 1916 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Director St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42370 Allison Drive 20659 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: if tiem 27 is marked other than "natural", or items 23.
ury or other fraumatic event, in Medical Earth art mult. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Secretary U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sebastian LaScola Beulah M. Rosenberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10203 Norwood Ct., Charlotte Hall, Maryland 20622 Robert J. Coffren / Step-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, Stete permit. Page Department o Important: If any injury or 4 □ Donation 5 □ Other (Specify) Charles Memorial Gdns. 7-9-2004 Leonardtown, MD 22. Name and Address of Facility Funeral Service Licensee Brinsfield Funeral Home, P.A. Mary United X 22955 Hollywood Road Leonardtown, MD 20650 M01114 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a condequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease of minury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 5 Other (specify) been signed by the a should be detached t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2.NO 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 2 No 1 Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 2NINO 1 🗌 Yes 3□ DOA Manager Home 5 Residence 6 ☐Other (Specify) Medical Certification; To this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attanding 5 Pending investigation 1 Natural nours after death. neral Director: Af filled in by the fu 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral E Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records.

23415 Three Notch Road, California, Maryland 20619

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boyd

8 2004

Year)

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JUL

James C.

31. Date filed (Month, Da

M.D.

trar's Signature

			For State Registrar	State of M	aryland /	-	artment of He rtificate of D		Mental Hy	giene	004	23629	
			1. Decedent's Name (First, Middle, La	st)					2. Date of De	ath		3. Time of Death	
	Physici /Medic		Fred Harlow Clark, Jr						Month July	Day 02	Year 2004	10:54 A. M	
	Examir		4a. Fecility Name (If not institution, give				4b. City, Town, or L	ocation of Death		7	ounty of Deeth	10,04	
			St. Mary's Nursing Ce	nter			Leonardtov	√n		St	. Mary's		
	Funeral		Social Security Number 6. S		ge (in yrs. last t	irthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da			lece (State or Foreign	
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	s 23g	Funeral	23639 Point Lookout R				20650			USA			
	er de litem	nue	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14	. Race - America Black, White, e		
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	140		1☐Yes 2☐No	Specify:		S	pecify: Whi	te	
Ö	filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or items 23s or 28s-f show ont, the Medical Examiner must be notified at	ed	15. Decedent's Ed		16	a. Deced	lent's Usual Occupati	on		16b Kind	of Business/Ind	histor	
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ğ	othe ont,	BeC	17. Father's Name (First, Middle, Last)				1	8. Mother's Nam	e (First, Middle,		ımame)		
a	fenta fenta rked	To B	Fred Harlow Clark, Sr					Mary NMN V	Waddell				
Maryland 21215-0036	shou a ma uma		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailin	g Address (Street an			er, City or T	own, State, Zip	Code)	
	alth a 27 is		Myrick Clark/Brother		91	02 Sh	elley Road,	Raleigh No	27609				
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23s or 28s-f ahow any injury or other traumatic avent, the Medical Examiner must be notified at angle.		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place)	-	Date	20c. Loca	tion - City or Tox	wn, State	
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m	Depa Impo any ii		1 Kule	nas		Ma P.	ttingley-Gar O. Box 270 I	diner Fun	eral Home n MD 206	P.A.			
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3	Physician	8.9	shock, or heart failure. List only Immediate Cause (Final	one cause on each i	Para	<	AL	Uman	100		1	Interval Between Onset and Dealin	
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Вох	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		/	le			230	I. Date of deliver	4	
	deatl e atte	lc la	in the past 12 months?	1 Live birth 4 Pregnant a			Ectopic pregnancy Other (specify)				Month [Day Year	
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Division of Vital		E	27. Manner of Death	28a. Date of Inju	ry 28b.	Time of	28c. Injury a Work?		28d. Describe h				
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	P in the	Certification:	4 D HOMICIO	building, et	c. (Specify)				City or Tow	vn, State)			
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledg	je, death	occurred at the time,	date and place,	and due to the	cause(s) an	d manner as sta	ted.	
	n 24 n 24 na Fu	edical	(Check only one) Medical Exam	niner: On the basis o and manner st	f examination a ated.	nd/or inv	estigation, in my opin	ion, death occurr	ed at the time, o	date and pla	ace, and due to t	he cause(s)	
	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier			1.61	29c. License n	umber		29d. Date s	igned (Month, D	ay, Year),	
			1 Jama	14 has	175	N	1	064	19	17-	10-1	74	
	W.		30. Name and a rees of person who	completed use of c	leath	11.00,	rint)		. (1		1	
_	4		Dr. James P. Jarboe	, 24035 Thre	e Notch	Road,	Hollywood,	MD 20636					
	Sta		31. Date filed (Morth, Day, Xear) 20	D4 32 Registr	ar's Signature	B							
	Registr	ar	JUL 0 7 20	TUT	ا الحالات الحالة		1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Chiaravalloti Anna **Physician** 10:30 PM July 18 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Taneytown Carroll County 95 Kenan Street If Under 1 Year | tf Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. March 14 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F 1920 Italy 137-30-3244 Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be netitied at 1 Yes 2 □ No Maryland Carroll County Taneytown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 95 Kenan Street United States Be Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) healthcare worker healthcare 8 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: if Item 27 Is marked other any injury or other traumatic event, Item 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pietro Ippolito Rosa Maria 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sal Chiaravalloti / son 25 Andrea Driva Rockaway Borough, NJ 07866 20b. Place of Disposition (Neme of cemetery, crematory or other place) July 22 2004 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 MOther (Specify)Entombment Gate of Heaven Cemetery East Hanover, NJ 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Fugeral Service Licensee 136 East Baltimore Street Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Alzheine **Physician** 2 year disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2X No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Naturat 5 Pending 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a tX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D41619 1017 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Lerner, 63 Thomas Johnson Drive Frederick, Maryland 21702 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

	_	- State Registra AMEND ITEM		FER PR	3 6030	lillicate	e or De	auri		Reg. N	2001	23631
Physician /Medical		1. Decedent's Name <i>(First, Middle, I</i> Scott Warren	,			Dougla	ass		2. Date of Month	D	ay 2004	3. Time of Death 1340 P M
Examiner		4a. Facility Name (If not institution, g		E)		4b. City, T SEVE	Town, or Loc ERN	cation of De	ath	4	c. County of De	aath ARUNDEL
uneral irector		212-92-6109	.Sex 1XQXM 2□F		last birthday) 38 Yrs.	If Under 1 Months		Under 24 H lours M	8. Date of (Month, Dec.	Birth Day, Year 5 , 196	9. B 05 Ca.	sirthplace (State or Foreig Country) lifornia
or 28e-f show a radified at		Usual Residence of Decedent 10a. State 10b. County Maryland Anne A	rundel		ity, Town or Lo	ocation						10d. Inside City Limit:
3a or 28 at be not		10e. Street and Number 7950 Heather Mi	st Drive			10f. Zip (144			itizen of What of Lted Sta	•
34, or Itams 23a or 28e-f s 34, the rough by multipa by Funeral Director	2	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Amed Ford 1 Tyes 2 If Yes, Give Year or Da	ces? Ž O No		Was Decede If Yes, speci 1 Yes 2	ify Cuban, N	nic Origin? Nexican, Pu pecify:	(Specify Yes or erto Rican, etc.)	No-	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
neture lical sted		15. Decedent's (Specify only highest of Elementary/Secondary (0,12)	Education		(Give	dent's Usual kind of work DO NOT use	k done durin	n ng most of v	vorking		Kind of Busines	
s marked other then " umatic event, the Mac To Be Compile	2	17. Father's Name (First, Middle, La Wayne G.	st)	-	Douglas	ss		Mother's N	ame (First, Midd			Adams
7 Is marka traumatic To		19a. Informant's Name/Relationship Carolyn Garrett			19b. Mailir	ng Address ((Street and	Number or	Rural Route Nun			
nt: If item 2 ry or other	- 2	20a. Method of Disposition 1 □ Burial 2 ② Cremation 3 `4 □ Donation 5 □ Other (Special Control Cont	☐Removal from S		Place of Dispo	sition (Name	e of her place)		Date	20c. L	ocation - City o	
Importar any injur once.		21. Signature of Funeral Service Lic		dt								A. Yland 2070
sician edical		Immediate Cause (Final disease or condition	/1						ac or respiratory			Interval Between
nysiclan and he burial-transit so an including the burial transit so an including the burial transit so an including the burial examiner s		Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	r as a conseq	M) I+ CT quence of):				1			Interval Between Onset and Death
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Atter this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit tion; To Be Completed by Physician/Medical Examiner	F 2 2	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating inve	Due to (o b. Due to (o c. Due to (o d	r as a consequence of as a consequence of pregnath 2 Feta and at time of diminishment 2 Injury Day Year) If Injury - At hot, etc. (Specification of examina)	quence of): quenc	Dectopic prediction of the control o	ognancy cify) use given in 26. Other: Work? 1 Yes office	Place of D	23e. Dick 1 Can We aut 1 Yes eath (Check only Home 5 Re 28d. Describe City or T	I tobacco Yes 2 Is an opsy formed? 2 I No r one) sidence how inju (Street ar	Month use contribute No 3 F 24b. Were a prior to death? Other (Spiny) occurred SHCT SEC	onset and Death onset and Death elivery Day Year to the cause of death? Probably 4 Unknown autopsy findings available completion of cause of s 2 No ecity) AT SCEN
this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit. To Be Completed by Physician/Medical Examiner.	F 2	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate of Could not determine (Check only 2 Medical Exitations)	Due to (o b. Due to (o c. Due to (o d	r as a consequence of as a consequence of pregnath 2 Feta and at time of diminishment 2 Injury Day Year) If Injury - At hot, etc. (Specification of examina)	quence of): quenc	DEctopic prediction of the state of the stat	ognancy cify) use given in 26. Other: Work? 1 Yes office	Part I. Place of D. Nursing 2 No ate and place on, death occurrence on the occurrence of the occur	23e. Dick 1 Can We aut 1 Yes eath (Check only Home 5 Re 28d. Describe City or T	I tobacco] Yes 2 Is an opsy formed? 2 No rone) sidence a how inju [Street arown, State own, State a, date and 29d. Da	Month use contribute No 3 F 24b. Were a prior to death? Second Other (Spiry occurred) SHCT SC and Number or F a) July 100 100	onset and Death alivery Day Year to the cause of death? Probably 4 Unknown autopsy findings available completion of cause of s 2 No AT SCEN Gural Route Number Gural Route Number Autor Military as stated. e to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year John Dimeo JULY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | if Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 544-14-8937 84 19, 1920 Oregon Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location r than "naturs!", or Items 23s or 28e-f show the Medical Example: remark the notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland | St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21859 Indian Bridge Road 20619 filed within 72 hours after death USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No 1942-If Yes, Give Year or Dates: 1946 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2XNo Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Year Budget Analyst Federal Government 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If tiem 27 Is marked others any injury or other traumatic svent 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank S. Dimeo Theresa S. Sarli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rep 21735 Indian Bridge Road, California VI) 20619

20b. Place of Disposition (Name of Date 20c. Location - City or Town, State James Michael Norris/ Per. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Holy Face Church 07/20/2004 Great Mills, Maryland 21. Signatur , of Funeral Service Chanse 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failute. List only ene cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Resimratory 6 days /Medical Due to (or as a consequence of): Examiner SOPNI 10 days Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Iner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit by Physician/Medical Exam Due to (or as a consequence of): P.O. Box 68760, use as i IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2.No 3 Probably 4 □Unknown Be Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physicien: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural Injury 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5C 6a6-4 118 04 D5 4346 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAH ASSOC HOLLYWOOD CHANDRA SA.I.IA 20636 MD. 31. Date filed (Month, Day, Year) State JUL 2 0 2004 Registrar

JOHN DIMEO

			1 - For State Registrar	State of M	laryland / De	oartment of e <i>rtificate o</i>		_	giene	L 23633	
	Physici		1. Decedent's Name (First, Middle, Last) $L\epsilon$	onard (George	Donahue		2. Date of Dea Month July	Head Car Co.	Year 5:15 A M	
	/Medic Examir		4a. Facility Name (If not institution, give st	reet and number,)		or Location of Do		4c. County of	of Death	_
	Funeral Director		5. Social Security Number 318-01-4625 Usual Residence of Decedent	M 2□ F 7. A	ge (In yrs. last birthda 90 Yrs.	y) If Under 1 Yea Months Day		Hrs. 8. Date of Birt fin. (Month, Day August 1	th y, Year)	Birthplace (State or Foreign Country) Illinois	n
	Maryland s-f ehow	tor	10a. State 10b. County Maryland Calvert		10c. City, Town or Lusby	Location				10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	th with the 23a or 28i	al Director	10e. Street and Number 13049 Mills Creek Road			10f. Zip Code 206			10g. Citizen of W USA	/hat Country?	
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 ie marked other than "naturel", or Items 23a or 28a-1 ehow or other treumatic event, the Mardical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S. 13 No	B. Was Decedent of If Yes, specify Co		(Specify Yes or No- lerto Rican, etc.)	14. Race Black Specify:	e-American Indian, k, White, etc. . White	
Maryland 21215-0036	s within 72 ho piene. r than "natu the Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 12		5+) (Gi	edent's Usual Occ ve kind of work don DO NOT use reti ftsman	eupation ne during most of t red)	working	16b. Kind of Bus		
yland	should ba filed ind Mental Hygie marked other in	To Be C	17. Father's Name (First, Middle, Last) George Bernard Donahue		'		Janet	Name <i>(First, Middl</i> e, Wright Blyt	h	,	
e, Mar	1 and 2 sh 4ealth and em 27 ie m ther treum		19a. Informant's Name/Relationship (Type Judy Donahue Larsen/Date 20a. Mathed of Sizearities	•	1304	9 Mills Cr	eek Road, 1	Rural Route Numbe	0657		
Baltimore,	parmit. Pages Department of F Important: If ite eny injury or of		20a. Method of Disposition 1 □ Burial 2XX Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signa for of Funeral Service Licensee		Metropoli	position (Name of ematory or other p tan Cremato	ory July		Alexandria	City or Town, State	
Ba	Darm Depa impo eny i		23a. Part1. Enter the disease, of complice shock, or heart failure. List only one	Had	ment		P.O.	Box 270 Lec	onardtown,	neral Home, P.A. Maryland 20650	
	Pnysician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)		a configuence of):		least	Failur		Interval Between Onset and Death	
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last d.		a consequence of):						
.O. Box 68	eath certifi attending for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	□Ectopic pregnar □ Other (specify)	су		23d. Date Mont	of delivery th Day Year	
Records, P	w requires that the dibean signad by the should be detached	by	Part II. Other significant conditions contr	ibuting to death b	out not resulting in the	underlying cause o	even in Part I.	23e. Did to	~ ~	oute to the cause of death? B Probably 4 Unknown	
	(0	Completed						24a. Was a autops perform	sy pri med? de	ere autopsy findings available for to completion of cause of eath?	
of Vital	Phys this rat di	n; To Be	27. Manner of D ath	spital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Inj	ther: 4 Vursing	eath Check onl on Home 5 Residence 28d. Describe ho			
Division	Hospitel or Attending P 24 hours after death. Funerel Director: After t tely filled in by the funera	Certification;	Alatural 5 Pending Accident 5 Pending Accident 5 Pending Investigation Could not be Homicide determined	28e. Place of In	iury - At home, farm, s c. (Specify)	M 1{	Yes 2 □No	28f. Location (SI City or Town	treet and Number n, State)	r or Rural Route Number,	
_	Hospite 4 hours Funere ely fille	Medical Ce	29a. Certifier (Check only one) Certifying Physic (2 Medical Examine	cian: To the best or: On the basis o and manner st	t examination and/or	ath occurred at the nvestigation, in my	time, date and pla opinion, death oc	ce, and due to the cacurred at the time, d	ause(s) and mann ate and place, an	ner as stated. Indicate to the cause(s)	
	To the within 2 To the complete	W	29b. Signature and title of confier	de	J. Sell	29c. Licer	nse number	12 2	9d. Date signed ((Month, Day, Year)	
1	24,		30. Name and address of person who com Joseph J. Barth, M.D.,	110 Hospi	ital Road, Su		rince Fred	erick, MD 20	0678		
	Sta Registra	- 9	31. Date filed (Month, Day, Year) JUL 6 2004	3° Registr	ar's Signature	and when					

DHMH 17 Rev 1/2001

ORIGINAL

				artment of Health and Mental Hygic rtificate of Death	
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Adele Marie Feeney	2. Date of Death Month July 16, 2	Day Year 2004 4:15 P M
	Examir		4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center	4b. City, Town, or Location of Death Leonard town	4c. County of Death St. Mary's
I	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2★ F 7. Age (In yrs. last birthday, 93 Yrs.	Dif Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y February 28	9. Birthplace (State or Foreign Country)
	ne Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le Maryland St. Mary's Leonardtown		10d. Inside City Limits 1 ☐ Yes 2∰No
	th with the		10e. Street and Number 41665 Mattingly Street	2015	g. Citizen of What Country? USA
036	ours after dea al', or items Everit at me	by Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-1 show avant, the Medical Evar, activast be notified at	Completed	(Specify only highest grade completed) (Give	Nind of work done during most of working DO NOT use retired)	Own Home
ryland	be be be	To Be C	17. Father's Name (First, Middle, Last) Charles Fillmore Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	18. Mother's Name (First, Middle, Ma. Della Reed Ching ng Address (Street and Number or Rural Route Number, C	
Baitimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other traumatic <u>phce.</u>		Alice Jeannette Dakis/Sister 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Box 94, Leonardtown, MD 20650 sition (Name of pate) Date 20650	c. Location - City or Town, State ashington, DC diner Funeral Home, P.A.
	requires that the death certificate be executed a manage of the attending physician and nould be detached for use as the burial-transit	dical Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, such as cardiac prespiratory arrest, Immunity Faylor Taylor Taylor Taylor	Approximate Interval Between Onset and Death O
O. Box b	that the death certific ed by the attending p detached for use as	hysiclan/Med		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
ecords, P	w requires that s been signed b should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 23e. Did tobac	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Lec	The law ate has b page 2 sl	Completed	Jet East Ext His	Auma) 40 24a. Was an autopsy performed 1 Yes 2	
JIVISION OF VITAL	To the Hospital or Attending Physician: within 24 hours after deals To the Funaral Director: After this certific completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? Yes 2 No	28c. Injury at Work? M 1 Yes 2 No	
5	To tha Hospital or a within 24 hours after To tha Funarat Direst On the Funarat Direst Ompletely filled in the formula of the first of		building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	City or Town, Si	tate)
	To the Hi within 24 To the Fi complete	Medical	(Check only one) Medical Examiner: On the basis of examination and/or invariant magner stated. 29b. Signature and title of certifier	restigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s) Date signed (Month, Day, Year)
6	S		30. Name and address of person who completed cause of death (Item 23a) (Type, Dr. J. Patrick Jarboe, MD. 24035 Three Notch	Print) Road, Hollywood, MD 20636	1 11 47
	Sta Registr	1000	31. Date filed (Month, Day, Year) 32. Registrar's Signature	And a	

			1 - For State Registrar		artment of Health and Ment rtificate of Death	tal Hygiene	004 23636
	Physic	ion	1. Decedent's Name (First, Middle, Last)			ate of Death Month Day	3. Time of Death
	/Medi		George John Fort	unato, Sr.		1y 15	2004 10:00P ^M
	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	4c. (County of Death
			St. Mary's Nursi		Leonardtown		. Mary's
	Funeral		5. Social Security Number 6. Sex	IM SITE	If Under 1 Year If Under 24 Hrs. 8. D.	ate of Birth Nonth, Day, Year)	Birthplace (State or Foreign Country)
	Director		579-40-9358 'F	72 Yrs.	No	v. 13, 19	31Washington, DC
	land M		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	f ah	0	Maryland St. Mary's	Danier			1 Yes 2 No
	28a	rec	10e. Street and Number	s Dameron	10f. Zip Code	10g Citiz	en of What Country?
	3a or	0	49530 Wills Road		20628	USA	on or timal obtains
	death ms 2	Funeral Director		12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Specify Y f Yes, specify Cuban, Mexican, Puerto Rican		4. Race - American Indian,
9	or ite	Ē	1 Never Married 2 Married	1 Yes 2 No 1952 —		i, etc.)	Black, White, etc.
03	ral', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1954	1 ☐ Yes 2 🛣 No Specity:		Specify: White
21215-0036	be filed within 72 hours after death with the Maryland tall Hyglene. Id other than "natural", or Items 23e or 28e-f ahow other than "natural", or Items Cae recitied at event, the Medical Exam are must be recitied at	Completed	15. Decedent's Educ (Specify only highest grade		dent's Usual Occupation kind of work done during most of working	16b. Kin	d of Business/Industry
21	ithin	npl	Elementary/Secondary (0-12)	College (1-4or 5+)	OO NOT use retired)		
	filed w Hygier other th	Ö		5 years Ste	amfitter		anical Contractor
pu	be fill d otl	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (Firs		Surname)
yla	2 should be f and Mental H Is marked of aumatic eva	2	Nicholas Fortunato		Virginia Ro		
Maryland	s 1 and 2 should I Health and Mer item 27 is merke other traumatic	l i	19a. Informant's Name/Relationship (Typ	oe, Print) 19b. Mailin	ng Address (Street and Number or Rural Rou	te Number, City or	Town, State, Zip Code)
	s 1 and if Health item 27 other tr		Nancy E. Fortunato	/ Wife P.O. 1	Box 124, Dameron, Mar	ryland 20	628
Baltimore,	0 0	1 8	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re	emoval from State cemetery, cren	natory or other place)		ation - City or Town, State
Ë	permit. Pag Department Important: I any injury c		'4 □Donation 5 □ Other (Specify)	MD Vetera	ns Cemetery $07/22/20$	04 Chelt	enham, Maryland
39	Departm Departm Importal any inju		21. Signature of Funeral Service License	De 11/1/1/22	. Name and Address of FacilityBrinsf:	ield Fune	ral Home, P.A.
	40380		11 WW IVE		2955 Hollywood Road,		own, MD 20650
				cations that caused the death. Do not enter the cause on each line.	er the wode of dying, such as sardiac or resp	piratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	KELDURA	In Fallers		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons - u-nce of):	1.4		W
	200	L.	Sequentially list conditions, b	Carre	norhaldsel		month
_	5 ± 8d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	1 220		1 , , D
	and and Il-trar	хап	that initiated events c. resulting in death) Last	Due to (or as a consequence of);	- Cancel		1 years
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical E		240 (0) 40 4 0011004401100 01/.			
387	phys the	edic	d.				V
9 x	eath certific attending p for use as f	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			
Вох	atten for u	Physiclan/M	in the past 12 months?	1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	23	ld. Date of delivery Month Day Year
0	at the de by the stached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	Cities (specify)	-	
۵	that led by deta		Part II. Dther significant conditions conf	tributing to death but not resulting in the un	derlying cause given in Part I. 2	3e. Did tobacco use	e contribute to the cause of death?
ds	uires t signe Id be	d by				1 ☐ Yes 2 🗃	
Vital Records,	w requir been si should	Completed				4- 105	0.0
Re	The lay ate has page 2	m d			24	4a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
		ပိ	25. Was case referred to medical			☐ Yes 2 No	1 Yes 2 No
₹		00	examiner?	ospital:	26. Place of Death Che	2-7-2-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-	
		. To	1 ☐ Yes 2 ♠ No	1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	4 Wallstrig Home 5	Besidence 6 lescribe how injury	
o	ding R th. After funer	tlor	1 ♠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No	,,	
Division	or Attending after death. Director: After I in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, stre		ocation (Street and	Number or Rural Route Number.
-=	r i te	Certification;	4 Homicide	building, etc. (Specify)		ity or Town, State)	
	spite		29a. Certifier 1 Certifying Physi	ician: To the best of my knowledge, death	occurred at the time, date and place, and du	e to the cause(s) a	nd manner as stated.
	e Ho	edical	(Check only 2 Medical Examin	er: On the basis of examination and/or invi and manner stated.	estigation, in my opinion, death occurred at the	he time, date and p	lace, and due to the cause(s)
	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Me	29b. Signature and title of centrier	011	29c. License number	29d. Date	signed (Month, Day, Year)
	(SA		hme	al & SoulonEMI	D 06419	7-	-16-04
-	12		30. Name and address of person who con	impleted cause of death (Item 23a) (Type, F	Print)	/	00 - 1
	.0.		James P. Jarboe, M.	.D. 24035 Three Note	ch Road, Hollywood, N	Maryland	20636
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registar's Signature	Burks		

			1 - For State Registrar	State of Maryla	•	artmer <i>rtificat</i>			ınd M	ental Hy	gien Reg. N	2001.	23637
			Decedent's Name (First, Middle, Las	t)						2. Date of De	ath		3. Time of Death
	Physici /Medic		Carrie Janice Far	ris						Month JULY	06	2004	8:30 p M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location o	f Death		4	c. County of Deat	
			St. Mary's Hospit				ardt					St. Mary	's
	Funeral		5. Social Security Number 6. Se	7. Age (In yi	rs. last birthday)	Months Months	Days	If Under a	Min.	8. Date of Bi (Month, D	ay, Yea	r) Co	hplace (State or Foreign ountry)
	Director		268-22-4164 Usual Residence of Decedent		78 115.					July 1	4,	1925 Ken	tucky
	land ow		10a. State 10b. County	10c.	City, Town or L	ocation							10d. Inside City Limits
	the Marylan 28a-f ahow cytified at	ţō	Maryland St. Mar	y's Ca	aliforni	La							1 ☐ Yes 2 No
	h the	lrec	10e. Street and Number			10f. Zip	Code				10g. C	Citizen of What Co	ountry?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow the Madical Examinar mast he notified at	Funeral Director	44693 White Oak C	ourt Apt # 51	19	20	619				US	A	
	r dea	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Dece	dent of Hi	spanic Orig	gin? (Spec	cify Yes or Na Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 MNo II Yes, Give		1 🗆 Yes		Specify:		. ,		Specify:	0, 0.0.
215-0036	hours tural',	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	160 Dags	deette Her	al Oanua	-4:			1.05		ite
15-	n 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usu kind of wo DO NOT u	nk done o	during most	of workin	g	160.	Kind of Business/	industry
212	withi ene. than	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		ail C		,			Ci	vil Serv	riaa
	ould be filed with Mental Hygiene arked other than atic event, then	Be C	17. Father's Name (First, Middle, Last)		NeLa	1111	LEIK	18. Mothe	r's Name	(First, Middle			rce
<u>a</u> n	lid be lental ked c	To B	George J. Lovell					Minni	ie Ma	e Ower	ıs		
Maryland	S D E E	_	19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Addres	s (Street a	and Numbe	r or Rural	Route Numb	er, City	or Town, State, 2	Zip Code)
	1 and 2 Health a tem 27 is		Donna F. Wible/Da	ughter	1037	Asseı	mbly	Drive	e, Vi	rginia	і Ве	ach, VA	23454
Baltimore,	permit. Pages 1 al Department of Hea Important: If item any injury or othe once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		. Place of Dispo cemetery, cre	osition (Na. matory or o	me of other place	e)	Da	ate	20c.	Location - City or	Town, State
<u>E</u>	Pages ment of I ant: If its ury or o		'4 □Donation 5 □ Other (Specify		nmaculat	e He	art c	of Mai	cy 7/	10/200	4 L	exington	Park, MD
alt	permit. Pa Departmer Important: any injury		21. Signature di Funeral Service Licen		111 2	2. Name a	nd Addres	s of Facility	Brin	sfield	l Fu	neral Ho	me, P.A.
m	897 29		1 July Kiz-	20 MILLI								dtown, M	D 20650
	Physician /Medical Examiner	ıminer	23a. Fart1. Ener the disease, or corn shock, or heart failure. List only the term of the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events	a. Due to (or as a cons	Stive sequence of the	Hear	t f	ailur	2				Approximate Interval Between Onset and Death
x 68760,	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical Examiner	IF FEMALE:	d				·	<u> </u>			23d. Date of del	
O. Box	that the death cer ed by the attendin detached for use	nysician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	⊒Ectopic p ⊒ Other (s _i						Month	Day Year
rds, P.	98 09 09	by	Part II. Other significant conditions of	ontributing to death but not i	resulting in the u	inderlying (cause give	en in Part I.				use contribute to 2 No 3 Pr	the cause of death?
Records,	ystcian: The law requir is certificate has been si director, page 2 should	Completed								24a. Was auto perfo	psy ormed?	prior to death?	utopsy findings available completion of cause of
Vital	an: Tiffical	a)	25. Was case referred to medical					26. Place	of Death	(Check only	2 🗷 N	10 10105	2 140
>	Physician: this certific ral director,	OB	examiner? 1 Yes 2 WNo	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 De	Oth e	261				6 ☐Other (Spec	cify)
J of	ding Ph n. After th funeral	T :u	27. Manner of Death 1 □ Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	of :	28c. Injury Work			8d. Describe			•
Ö	Attending r death. ector: After by the fune	atlo	2 Accident investigation	1	,	М		Yes 2 1	No				
Division	i gite	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st ecify)	reet, factor	y, office		2	8f. Location (City or To			ural Route Number,
	the Hospital nin 24 hours a the Funeral i	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my l niner: On the basis of exam and manner stated.	knowledge, deal ination and/or in	th occurred ivestigation	at the time t, in my op	ne, date and pinion, deat	d place, a th occurre	nd due to the id at the time,	cause(date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	N. M m	121	29	c. License	number			29d. D	ate signed (Monti	h, Day, Year)
	1,50) I PW	MAKU	1/2	Ü	200	250	539	0	0	106	0
	4.6		30. Name and address of person who	- 1/1/								1 -	
			31 Date liled (Month: Day Year)	, St. Mary	s Hosp	ıtal,	Leon	nardto	own,	MD 2.06	50		
. 4	Sta Regist		31. Date liled (Month Day, Year) 2	004 32 Degistrar's Sig	A A	Lowell	2						

CARRIE JANICE FARRIS

			For State	State of M	laryland / Depa <i>Ce</i>	artment of He <i>rtificate of D</i>		ental Hygien Reg. N	~ ~ ~ .	22600
	11:		Registrar 1. Decedent's Name (First, Middle, La.	st)				2. Date of Death Month Da		3. Time of Death
	Physici /Medic		Sharon	Ann	Gi	nevan		July 15,	2004 Year	5:50 p. M
	Examin		4a. Facility Name (If not institution, giv)	4b. City, Town, or L	ocation of Death		c. County of Death	1
	F		18005 Ginevan W 5. Social Security Number 6. S		ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	B. Date of Birth (Month, Day, Year	Allegany 9. Birth	place (State or Foreign
	Funeral Director			D. 4 0 CB-C	57 Yrs.	Months Days	Hours Min.	Dec 15, 19	946	MD
	pud 🔏		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla f eho	ō	MD Allega	ny	Oldto					1 ☐ Yes 2 ☐ No
	r 28e	Irec	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	untry?
	23a c	ra D	18005 Ginevan W	ay			1555		USA	
	ltems ret	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden	?	Was Decedent of His If Yes, specify Cuban,	panic Origin? (Spec , Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Amer Black, White	
036	72 hours after death with the Maryland natural; or Items 23a or 28a-f ehow dical Examiner must be notified at	by	3 ★ Widowed 4 Divorced	1 Yes 2 7 If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: whi	te
5-0	72 hours 'natural', dical Exa	Completed	15. Decedent's E (Specify only highest gra		16a. Dece (Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of working	16b. I	Kind of Business/I	ndustry
121	be filed within 72 ho htal Hygiene. ed other than "natur event, the Medical	duc	Elementary/Secondary (0-12)	College (1-4or	Home				n Home	
197	e filed within Il Hygiene. other than vent, it e M	Be C	17. Father's Name (First, Middle, Last)	1.101110		18. Mother's Name ((First, Middle, Malde		
ylar	2 should be and Mental Is marked o eumetic eve	ToE	Theodore Swan					Mummert)		
ā	and man		19a. Informant's Name/Relationship (Cindy Crabtree	_{Турв, Print)} daug		ng Address (Street an 00 Levi Roa		Route Number, City Oldtown		p Code) D 21555
	of Health of Health fitem 27 I		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place)	Da		_ocation - City or T	
Ë	Page nent c ant: If ury or		1		Long Ceme			/18/2004 OI	dtown	MD
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice	1see	2001- 2	2. Name and Address Scarpelli 108 Virgin		ne, PA Cumberland	MD 2150	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do not en line.	ter the mode of dying,	such as cardiac or	respiratory arrest,	, IVID 2 I 3 04	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Brea	ST CA	MOCE!	2		Onset and Death
	/Medical Examiner		1 and the second	Due to (or a	s a consequence of):					,
L		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of):					
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequence of):					
8760,	cate be executed physician and s the burial-transit	dical E		d	s a consequence or,					
	tificate ng phy: as the	ledic		_ u						
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	⊒Ectopic pregnancy			23d. Date of deliver Month	very Day Year
0	at the dea by the a trached fo	Physician/Me	1 Yes 2 No	4∏Pregnant a 9∏Unknown	at time of death 5	Other (specify)				 , ,
ď.	The law requires that the death certificate has been signed by the attending age 2 should be detached for use a	by Ph	Part II, Other significant conditions	contributing to death	but not resulting in the u	inderlying cause given	in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ğ	w require been sig should b	ted t	DiAbetes					1 ☐ Yes 2	No 3∏Pro	bably 4 Unknown
of Vital Records,	elawr hasbe ye 2sh	Completed						24a. Was an autopsy performed?	24b. Were aut prior to co	opsy findings available ompletion of cause of
a		e Co	25. Was case referred to medical				OC Plans of Paralle	1 ☐ Yes 2 ☐ N		2 □ No
\equiv	S S	To Be	examiner?	Hospital:	ient 2 🗆 ER/Outpatie		26. Place of Death / 4 □ Nursing Home	e 5 K Residence	6 ☐ Other (Spec	fy)
n o	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, D	ury 28b. Time o	f 28c. Injury a Work?	at 28	d. Describe how inju		
Division	ttendi death. stor: A	icatl	2 Accident investigatio	9 - 51	njury - At home, farm, st		es 2 □ No	Rf. Location (Street a	nd Number or Ru	ral Route Number
Div	el or A s after Il Direct	Certification:	4 Homicide determined	building, e	etc. (Specify)	reot, factory, office		City or Town, Stat		a riodio ridingo.,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)	nysicien: To the bes miner: On the basis and manners	it of my knowledge, deat of examination and/or in stated.	h occurred at the time vestigation, in my opir	, date and place, an nion, death occurred	nd due to the cause(s d at the time, date an	s) and manner as ad place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	\ ^	1.0	29c. License i		29d. Da	ate signed (Month	Day, Year)
)) V	V /	INIC	D54.	+56	7	17 16	2004
	i.		30. Name and address of person who				1 100 0	11500		
	<i>Q</i> Sta	ate	Robert E. Rapp, M. 31. Date filed (Month, Day, Year)		trar's Signature	1	ing, MD 2	21502		
	Regist		JUL 2 2 2004	Serve	~ 19 1	parket				

Walter William Gover Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 04484State of Maryland / Department of Health and Mental Hygiene RJ 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Walter William Gover July 8, 2004 0915 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Kidds Schoolhouse Rd. @ Spook Hill Rd Baltimore County Freeland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1/**X**M 2∏ F 7. Age (In yrs. last birthday) 8. Date of Birth

(Month, Day, Year)

June 5, 1963 **Funeral** 9. Birthplace (State or Foreign Hours Months Days Min. 215-88-0255 41 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show must be notified at MD 1 ☐ Yes 2X No Baltimore Freeland Funeral Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23s or 20300 Middletown Road 21053 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic avant, the Mudical Examiner filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 'natural' Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 8 Construction othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith and Mental h Pages 1 and 2 should be Raymond Lamont Gover 2 Muriel Jane Barron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 is any injury or othar trau once. Esther Lee Gover, Sister 20300 Middletown Rd., Freeland, MD 21053 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date July 14, Mt. Carmel United 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Parkton, MD Methodist Cemetery 22. Name and Address of Facility 2. Signature of Funeral Service Licensee J.J. Hartenstein Mortuary, Inc 24 Second St., New Freedom, PA 23a. Part1. Enter the disease, or complications it at called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause hearth ne. Approximate Interval Between Onset and Death mediate Cause (Final Priyaidian rowning disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68766 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an

Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records,

Completed Be 2

25. Was case referred to medical

After

examiner' 1 X Yes 2 ☐ No 27. Manner of Death Certification: 1 Natural 2 Accident
3 Suicide Diractor: 4 Homicide 24 hours a 29a. Certifier Medical npletely

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) one

5 Pending

investigation

6 Could not be determined

lan 32. Registrar's Signature

JUL 12 0 2004

an ma

28a. Date of Injury (M.nth, Lay Year)

1/8/04

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

8:218

111 Penn Street, Baltimore, Maryland 21201

OCME

Other:

1 ☐ Yes 2 🗷 No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

There & Soules

autopsy performed? Yes

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

subject drowned

July 9, 2004

DUN VCT WWW. Location Direct and Number or Rural Route Number, City or Town, State) KIDG & School how & RA

29d. Date signed (Month, Day, Year)

26. Place of Death (Check only one)

2 🗆 No

within 2 tha

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month lliam OD PM A LLEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Princess Hnne
If Under 1 Year | If Under 24 Hrs. reise Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 218-16-9963 1 MM 2 □ F 84 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Industries after usean with the Marylan Important: If item 27 is marked other than "naturel; or Items 23e or 28a-f show any injury or other traumatic event, the Medical Exact set mast be notified at once. MD DOMERSET 1 Yes 2 The Rincess Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28465 Road 21853 ENTON Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Black δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' SEIF- Employed Elementary/Secondary (0-12) 64h College (1-4or 5+) arpenterus 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OWEIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Holbrook - Daughter 28465 Venton, RD Princess Ann 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Localion - City or Town, State 20a. Method of Disposition Date 1 ■Burial 2 □ Cremation 3 □ Removal from State Cometery 07-17-04 * 4 ☐ Donation 5 ☐ Other (Specify) Trinita 22. Name and Address of Facility Funeral Home Arthory E. Ward Funeral Home 30639 Hampden Ane Princess 21. Signature of Funeral Service Licenses 24853 21 Mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASWD yums /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine signed by the attending physician and defected for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Medical Certification; To Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0051359 July 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY 1415. S. DIVISION NATESAN ST DR. USHA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 4 2004

loger Gilliam

32. Resistrar's Signature

For State Registra

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

CHARLES IRA GARDNER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City. Town, or Location of Death

Reg. No

03

2000

29d. Date signed (Month, Day, Year)

1845

2. Date of Death

Month 07

Registrar DHMH 17 Rev 1/2001

within 2 To the

4 - Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

Medicai

State

ORIGINAL

and manner stated.

219

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

		ļ	For State	State of Mar	-	artment of Health and	Mental Hy	/giene
			Registrar 1. Decedent's Name (First, Middle, Lateral	st)		imodio of Bodin	2. Date of D	eath 3. Time of Death
	Physici		Marciano	P.	Hayag		Jul v	14. 2004 2:40 A M
	/Medio Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Location of De		4c. County of Death
			Southern Maryland			Clinton		Prince George's
	Funeral		5. Social Security Number 6. S 579-90-4844	ex 7. Age (₹M 2□F	(In yrs. last birthday) 90 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M		9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent				01/13	/1914 Philippines
	yland now		10a. State 10b. County	1	10c. City, Town or Lo	cation		10d. Inside City Limits
	e Mar	ctor	Maryland Prince (George's	Oxon Hil	<u>. </u>		1 ☐ Yes XXXXNo
	h with th	Funeral Director	10e. Street and Number 411 Hayworth Pla	ace		10f. Zip Code 20745		10g. Citizen of What Country? USA
	ems 2	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu-	(Specify Yes or Nerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. id other than "neturel", or Items 23a or 28e-f show event. I're Medical Evarified rust be notified at	by	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes ANNo If Yes, Give Year or Dates:		1 ☐ Yes XIX No Specify:		Specify: Filipin Asian
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupation kind of work done during most of w	vorking	16b. Kind of Business/Industry
21	vithin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired) E - Employed	3	Shoe Manufacturer
121	Hygiel Hygiel other th		8 17. Father's Name (First, Middle, Last,	1	501.1		ame (First Middle	a, Maiden Sumame)
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Mari	2 sho and Is ma		19a. Informant's Name/Relationship (ber, City or Town, State, Zip Code)
Baltimore, N	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other treumatic once.		Nelia Ignacio / 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo		Rd. Ft.	Washin ton MD 20744 20c. Location - City or Town, State
ij	Pag ment lant: I		* 4 □ Donation 5 □ Other (Specif	y) /	Resurrect	cion Cemetery 07	/19/2004	Clinton, Maryland
Ball	permit Depart Impor any in once.		21. Signature of Juneral Service Licer	Ly 6	22	2. Name and Address of Facility Geor 5160 Oxon Hill R	ge P. Ka 8ad Oxon	las Funeral Home P.A Hill, Maryland 20745
			23a. Part 1 Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death. Do not ent	er the mode of dying, such as card	iac or respiratory a	arrest, Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	METAS	TRIC C.	ANGER OF COL	40	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):			
		<u></u>	Sequentially list conditions,	b. Due to (or as a	consequence of):			
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events					
oʻ	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):			
8760,	cate be ex ohysician the buria	dical		d				
9	The law requires that the death certificate be executed ate bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Med	IF FEMALE:		- 77			
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year
Ö.	that the de ed by the a detached	yslc	1 Yes 2 No	4□Pregnant at tii 9□Unknown	me or death = 5 L	Other (specify)		
Δ.	ires that the signed by does detact		Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying cause given in Part I.	23e. Did	tobacco use contribute to the cause of death?
Records,	quires in sign	Completed by	ATHEROSLIER	CTIC CAR	DIEVASCA	LAR DISEASE	1 🗆	Yes 2 No 3 Probably 4 Unknown
00	aw requir as been si 2 should	plet					24a. Was	
R	The lav ate has page 2	mo		-			auto	ormed? death? 215 No 1 Yes 215 No
Vital	ysicien: The l is certificate ha director, page	Bec	25. Was case referred to medical examiner?				eath (Check only	one)
of V	Physicien: this certific ral director,	2	1 ☐ Yes 2 K No	Hospital:				idence 6 Other (Specify)
n O	ding P	lon:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day		Work?	28d. Describe	how injury occurred
isic	death. ctor: A the fu	icat	2 Accident investigatio 3 Suicide 6 Could not b	e 200 Place of Injun	y - At home, farm, str	M 1 ☐ Yes 2 ☑ No	28f. Location	(Street and Number or Rural Route Number.
Division	after Direct	Certification:	4 Homicide determined	building, etc.	(Specify)	oot, radiory, office	City or To	wn, State)
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medical C			xamination and/or in	n occurred at the time, date and pla vestigation, in my opinion, death oc		e cause(s) and manner as stated. , date and place, and due to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and manner state		29c. License number		29d. Date signed (Month, Day, Year)
	⊢ s ⊢ ŏ		1 Victor 5	lie	47	220986		7-14-04
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,			/-/¥-UI
	3		11701 LIVINGST		ORT VYAS		2074	4
	Sta Regist		31. Date filed (Month, Day, Year)	3. Registrar	s Signature	Sports		,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death :05 PM **Physician** William OSEPH JEROME man /Medical 4a. Fapility Name (If not institution, give street and number) 4b-City, Town, or Location of Death County of Death Examiner ANER MINICOS HONE
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Min Months Days Hours 1 MM 2□ F 214-16-4511 03-21-Director 10a State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylar Depertment of Health and Maniel Hygiane. Important: if Item 27 is marked other then "neturel", or Items 23e or 28e-f show eny Injury or other treumatic event, the Madical Examinat must be notified at MD 1 ☐ Yes 2 No Director ANOKIO Om cise 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8548 2-12-36 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SEIF - Employed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ellen W. Hayman JOSEPH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 110 21236 Fontaine 8548 RD Manakin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Samuel Wesley Campley Ol-1.-.,

22. Name and Address of Facility
Anthony E. Ward Funeral Ho
30639 Himpden Are Princess A Manokin *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licer Home 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) U Physician arcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and thed for use as the buriel-transit certificate be execut Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) signed by the a ibuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) To the Hospitel or Attending Pt within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2950 07-12-2004 los

Registrar

GREGORIO

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

36. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.

JUL 1 4 2004

			For Amend Item #8, p	State of Maryland	L/Depa	artment/96		nd Mental Hy		
				CI IIIOIIIIII,	Ce	rtificate of	Death			23644
н	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Yee	A.A
1	/Medic	al .	Martha Ine			4b. City, Town,	or Logation of I	JULY_	10 2004 4c. County of D	3:35 p
	Examin	er	4a. Fecility Name (If not institution, give s St. Mary s Hosps						St. Ma	
	Funeral		5. Social Security Number 6. Sex		st birthday)	If Under 1 Year				irthplece (Stete or Foreign Country)
	Director		231-03-4295	M 2 2 F 87	Yrs.	Months Days	Hours	Min. (Month, Da	1969 No	rth Carolina
	Z 2		Usual Residence of Decedent 10a, State 10b, County	10c City	Town or Lo	ocation				10d. Inside City Limits
	laryla ehov	5			101111 07 20		_			1 ☐ Yes 2 No
	28a-f	Director	Maryland St. Mary	y's		Lexing 10f. Zip Code	ton Par	:k	10g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f ehow Trusst be modified at		46569 Yorktown I	Road		20	653		United S	tates
	death	Funeral		12. Was Decedent Ever in U.S Armed Forces?	. 13.			n? (Specify Yes or No Puerto Rican, etc.)		merican Indian,
9	after or Ite		1 Never Married 2 Married	1 ☐ Yes 2 ∰ No If Yes, Give		1 ☐ Yes 2 █ No		dono risadii, oto.,		White
5-0036	hours after death with the Marylan ture!, or items 23a or 28a-f show al Examinar mast be modified at	d by	3 ₩idowed 4 Divorced	Year or Dates:	16a Dass	dent's Usual Occu	nation		16b. Kind of Busine	
5	within 72 ho ene. than "netur ne Medical	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	pation during most o ed)	of working	16b. Kind of Busine	ss/industry
12	the the	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		s Clerk			Departmen	t Store/Retai
ğ	il Hygid other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middle		
<u>la</u>	should be nd Mental marked o	To E	Thomas Arnold				F	larriet Sa	wyer	
Maryland	d 2 should th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship (Type	oe, Print)					er, City or Town, State	
	s 1 and f Health item 27 other tr	. 2	Charles A. Hugg	/ Son		9 Yorkto	wn Road	l, Lexingt	on Park, M 20c. Location - City	
Baltimore,	00====		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re	emoval from State	metery, cre	matory or other pla				
Ē			*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen#e			emorial (2. Name and Addr		7-14-2004		
Ba	permit. Departr Import. eny inj		David A. Goff	2Ho# M0109					d Funeral	Home, P.A. MD 20650-0279
, inc	- 1-30		23a. Part1. Enter the disease, or o mp. shock, or heart failure. List only on			er the mode of dy	ing, such as ca	rdiac or respiratory a	irrest,	Approximate Interval Between
	Physician		Immediate Cause (Final		ilure					Onset and Death
	/Medical		disease or condition resulting in death)				: /		(;	3000)
N	Examiner		Sequentially list conditions	multiple	Vive	er me	tersto	RIL	(h	or week
	ii g	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):	-(08) enor	isis areihon	a) kmc	un I week
	ecute and trans	Examiner	that initiated events cresulting in death) Last	Due to (or as a conseque		01 (014		201011	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
60,	eath certificate be executed attending physician and for use as the burial-transit	cal E		240 10 10 10 40 40 60 100 40	31133 31,1					
687	ficate phys s the		d							
Вох	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan		700			23d. Date of	delivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 Fetel of 4 Pregnant at time of dea		∃Ectopic pregnanc ∃ Other (specify) _			Month	Day Year
о. О.	at the de by the a tached	hys	9 Unknown	9□ Unknown	- 117-					
	res that igned be be det	by F	Part II. Other significant conditions con	tributing to death but not resul	Iting in the u	inderlying cause gr	- 11 -	to		But the cause of death?
ord	w require been signated should b	ted	Canara Ca	TOIG VISCOS	1.	. 1	-1			Probably 4 Unknown
Records,	e law has b	Completed	restableeding.	SIP Palli	attive		Stome	↓ auto		autopsy findings available to completion of cause of
			and resention	of colon	Cano	er in s		1 Yes	2 No 1 □ Y	
Vita	ysician: The is certificate hi director, page	o Be	25. Was case referred to medical examiner?	lospital:	:D/O-44-	- 20 POA Ot	han	Death (Check only		
ō	Phys or this oral dii	\vdash	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	R/Outpatie 28b. Time o	f 28c. Init	ırv at		idence 6 Other (S how injury occurred	респу)
on	nding P nth. : After e funera	atior	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork?]Yes 2 □ No			
Division of	or Attendi after death. Director: A in by the fo	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)		reet, factory, office		28f. Location ((Street and Number or wn, State)	Rural Route Number,
	tal or A	Certification;		J						
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,		(Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati						
	To the h within 24 To the F complete	Medical	one)	and manner stated.		29c Licen	ise number		29d. Date signed (Mo	onth Day Yeari
	To wit	~	29b. Signature and title of certifier	-20	mi			38		
	5		30. Name and address of person who co	ampleted cause of death /from	23a) (Tuna	Print	- ' /		1	0 - 0
3	نا		XAE T. AUT		ME	RVELL	DRA	NRD	HOLLYMO	04 OD MD 20636
6	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		house				

MARTHA INEZ HUGG

			For State Registrar	State o	f Marylan		artment rtificate					giene	004	23645				
	Dhysiai	an	1. Decedent's Name (First, Middle, La		2. Date of Dea Month	ath Day	Year	3. Time of Death										
	Physici /Medio		Mary Elizabe	th Ke	ating	Hanl	¢s				June	25,	2004	15 0 15 050				
	Examir		4a. Facility Name (If not institution, gi	ve street and nu	mber)		4b. City, T		Location of			4c. (County of Dea					
			45357 Daniels R		7 4 11 1	la sa bisab strui	If Under		Holly If Under	A	C. D. t. of Dist		St. M					
	Funeral			Sex 1 □ M 2 万 F	7. Age (In yrs. I	Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Day	y, Yea <i>r)</i>	0	rthplace (State or Foreign ountry)				
	Director		223-80-0758 Usual Residence of Decedent		74						Jan. 13	3, 19	30 Ha	iti				
	/land		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits				
	Mar.	ţō	Maryland St. M	lary's			Holly	vwoo	d					1 ☐ Yes 2 No				
	h the	Director	10e. Street and Number				10f. Zip					10g. Citiz	en of What C	ountry?				
	ath with the Marylan 23a or 28a-f show		45357 Daniels R	load				20	636			Un	ited S	tates				
	ems er.	Funeral	11. Marital Status	12. Was Dece	edent Ever in U. orces?	S. 13.	Was Decede	ent of Hi	ispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	- 1	4. Race - Am Black, Wh	erican Indian, ite etc				
98	or it		1 Never Married 2 Married	1 □ Yes If Yes, Gir	ve		1 ☐ Yes 2		Specify:		,			Thite				
21215-0036	72 hours after death with the Maryland neturel; or tems 23a or 28a-f show Jical Exa di eff dat be netfined at	d by	3 Widowed 4 Divorced	Year or D	ates:	10- P	dende Herrel		-11									
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12	Jwithin 7. jiene. r then "n ir e M.	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		maker		,				Отт Но	ımo				
Q	T the state of the		17. Father's Name (First, Middle, Las			Home	maker		18. Mothe	er's Name	Own Home Name (First, Middle, Maiden Surname)							
<u>a</u>	d a b e	o Be	Edmund Bernard	Keating					M	largu	rguerite Bonneau							
Maryland	d 2 should I th and Men 7 Is marke treumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a			or Rural Route Number, City or Town, State, Zip Code)							
	1 and 2 Health a tem 27 li	1 8	Norris Jay Han	ks / Hu	sband	4535	7 Dani	iels	Road	l, Ho	Hollywood, Maryland 20636							
Baltimore,	S		20a. Method of Disposition	□Removel from	l ~	lace of Dispo emetery, crea	osition (Nam matory or oti	e of her plac	(9)	D	ate	20c. Loc	ation - City o	r Town, State				
Ĕ	Pages nent of sent: If it ury or o		1 Burnal 2 Cremation 3 Hemoval from State								2004	Arli	ngton,	Virginia				
at	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	Taller	4	22	2. Name and	Addres	ss of Facili	y Br	insfiel	d Fu	neral	Home, P.A.				
ш_	20 E 2 9		David A. Gof		NO 1095								own, M	D 20650-0279				
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nglications that of y one cause on e	auced the death each line.	n. Do not ent	ter the mode	of dyin	g, such as	cardiac o	respiratory ar	rest,		Approximate Interval Between Onset and Death				
	Physician		Immediate Cause (Final disease or condition	N .	YELO (JYSPL	ALIA							12 months				
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):												
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b	(or as a consequ	uence of												
	bed nsit °	nin	Cause (Disease or injury	Duo to	(or as a consequ	aonoo oi).												
	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c Due to	(or as a consequ	uence of):												
8760	death certificate be executed e attending physician and nd for use as the burial-transit	dical		d														
9	ificat g phy as the	edlo																
Вох	eath certific attending pl	N/N	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		⊒Ectopic pre	cnancy				23	3d. Date of de	livery				
		icia	in the past 12 months? 1 □ Yes 2 ☑ No		nant at time of de		Other (spe						Month	Day Year				
P.0	The law requires that the de sie has been signed by the a bage 2 should be detached	Physician/Me	9 🗆 Unknown								T							
	es tha igned be del	b	Part II. Other significant conditions	contributing to d	eath but not resu	ulting in the u	nderlying ca	use give	en in Part I					o the cause of death?				
ord	w requir been s should	ted									101	es 2E	1NO 3 P	robably 4 Unknown				
Records,	e taw re has be je 2 sho	Completed									24a. Was autop	sy	orior to	utopsy findings available completion of cause of				
<u>—</u>		Co									perfor	2⊟No	death? 1 ☐ Ye	s 2 No				
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Cth			(Check only o							
ot		. To	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o	Sec.	A Bc. Injury			se 5 PResid			ecify)				
	ding f h. After funer	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Mon	th, Day Year)	Injury	м	Worl	k? Yes 2 🔲			,,	00001100					
Division	I or Attending after death. Director: After	ertification:	3 ☐ Suicide 6 ☐ Could not	be 28e. Place	of Injury - At ho	ome, farm, st	reet, factory,	office		2			Number or R	lural Route Number,				
á	る最高に	erti	4 Homicide	- build	ing, etc. (Specify	v)				- 4,	City or Tow	m, State)						
	spital hours a neral ly filled	alc	29a. Certifier 12 Certifying F	hysician: To the	best of my kno	wledge, deat	h occurred a	at the tin	ne, date an	d place, a	nd due to the o	cause(s) a	ınd manner a	s stated.				
	I 4 II 0	edical	(Check only 2 Medical Exa	and man	iasis of examination	tion and/or in	vestigation,	in my o	pinion, dea	in occurre	d at the time, o	date and p	place, and du	e to the cause(s)				
	To the within 2 To the complet	Σ	29b. Signature and title of certifier						number		3			th, Day, Year)				
)	D		1 and	~			<u></u>	SOF	ουφ			UX	1000	6/28/04				
2	7		30. Name and address of person who				,		_					. 00575				
	~		31. Date filed (Month, Day, Year)		25500	O Poin	t Lool	kout	Road	l, Le	onardto	wn,	Maryla	nd 20650				
	Sta Regist	. •	JUE 0	32. F	Maran.	- F3	Bon	30										

			State of Maryland	i / Depa		lealth and I	Mental Hy	_	23646
Physic /Med		Decedent's Name (First, Middle, Last) Billy Donald Hen	ry				2. Date of De Month July	Day Yee 04, 2004	
Exami Funeral Director	ner	4a. Facility Name (If not institution, give st 48581 Loblolly Lan 5. Social Security Number 200-14-1768	e 7. Age (In yrs. Ia	nst birthday) 78 Yrs.		Inigoes If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da October 1	4c. County of De St. Mar th ly, Year) 19, 1925	_
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mary		Town or Lo	nigoes				10d. Inside City Limits 1 ☐ Yes 2 ※ No
3a or 28e	I Direc	10e. Street and Number 48581 Loblolly Lan	e		10f. Zip Code 2068	34		10g. Citizen of What (•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Itams 23a or 28e-f show any injury or other traumatic event, the Medical Examinest must be notified at once.	by Funeral Director	11. Marital Status 1 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	i	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛱 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, lite, etc. White
ithin 72 houne.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire		king	16b. Kind of Busines	,
Defitition (e), Mary yiaring 4 In 13-0000 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examples. In the Medical Examples.	To Be Cor	12 17. Father's Name (First, Middle, Last) John Lawrence He	nry		Flight E	18. Mother's Nar		US Gove , <i>Maiden Suma</i> me) ta Holmes	ernment
nd 2 shou alth and N 27 is mar r traumat		19a. Informant's Name/Relationship (Typ Roslyn Monsees / D			Box 5, S			er, City or Town, State	, Zip Code)
Pages 1 a nent of Hea nt: If Rem		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	ace of Dispo metery, crer	esition (Name of matory or other pla an Cremator	сө)	Date 6, 2004	20c. Location - City of Alexandria,	
permit. Departmit imports any inju		21. Signature of Funeral Service License	Hendener I	. <u>М</u> . - Р	2. Name and Address attingley-0 .O. Box 270	Gardiner Fu Leonardto	wn, MD 206	650	
death certificate be executed death certificate be executed death certificate be executed e attending physicien and dor use as the burial-transit	Ical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	ence of):	er the mode of dyll	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death With Jrs.
nat the death certifical d by the attending phylelached for use as the	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3[Ectopic pregnanc Other (specify)	у		23d. Date of o	lelivery Day Year
		Part II. Other significant conditions con	tributing to death but not resu	lting in the u	inderlying cause gr	ven in Part f.		tobacco use contribute Yes 2 \(\text{No} \) 3	to the cause of death? Probably 4 Unknown
The lar	Completed						24a. Was auto perfo 1 Tyes	psy prior to ormed? death	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
Oi VILGI I Physician: Th rthis certificate ral director, pag	To Be	TE TES ZILANO		ER/Outpatier	II JU DON	ner: 4 🗍 Nursing H		idence 6 Other (Sp	pecify)
To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Place of Injury - At hor	28b. Time o Injury me, farm, st	M 1	ry at rk?]Yes 2 □ No		Street and Number or	Rural Route Number,
Hospitel or A 24 hours after Funeral Direction of the property	edical Cert	4 Homicide 29a. Certifier (Check only 2 Medical Exemir	building, etc. (Specity, sician: To the best of my knowner: On the basis of examination	vledge, deat	h occurred at the ti	me, date and place	, and due to the	cause(s) and manner	as stated.
To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.)	29c. Licen:			29d. Date signed (Mo	nth, Day, Year)
68	tate	30. Name and address of person who co Jeffery Brown, P.O. 31. Date filed (Month, Day, Year)		town, M					
Regis		1111 6 2004	By M	Sha	all p				

-				State o	t Marylan	•	artment of F <i>tificate of</i>		d Mental Hy	giene Reg. No	NL 2	361.7	
	Physici	an	1. Decedent's Name (First, Mic		garet John	ston			2. Date of De Month	Day uly 18, 200		. Time of Death	
3	/Medio		4a. Facility Name (If not institu			31011		4b. City, Town,	or Location of Deat			7.45 1 .141.	
<u> </u>				Egle Nursin	g Home				naconing		Allega		
	Funeral Director		5. Social Security Number 216-05-5837	6. Sex 1 □ M 28 1 F	7. Age (In yrs. 99	last birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	th ly, <i>Year)</i> ber 25, 1904	9. Birthplace Country) M	(State or Foreign aryland	
	land		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City	y, Town or Lo	cation				10d.	Inside City Limits	
	a-fsh	ctor	Maryland	Allegany				Lonacon	ing			1.⊠Yes 2□No	
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of			
	eath v	Funerai	11. Marital Status	18 Furnace Stre	et edent Ever in U,	S. 13. V	Vas Decedent of h	21539		- 14. Rac	U.S.A.		
Maryland 21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland f Healith and Mental Hygiene. f Healith and Mental Hygiene. other treumatic event, the Medical Examinations to coffied at	þ	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☒ Divord	arried Armed Fo	orces? 2.⊠No ve		f Yes, specify Cub I ☐ Yes 2上 No	an, Mexican, P Specify:	? (Specify Yes or No uerto Rican, etc.)	Bla	ck, White, etc. y: White		
20	72 ho natur	eted	15. Deced (Specify only hig	ent's Education hest grade completed)		16a. Deced	lent's Usual Occup kind of work done OO NOT use retire	ation during most of	working	16b. Kind of B	usiness/Indust	ry	
121	within ene. than	Completed	Elementary/Secondary (0-12	College (1-4or 5+)	life. L	OO NOT use retire	Textile			Labore	er	
d 2	filed Hygie other	Be Co	17. Father's Name (First, Midd	/e, Last)	•				Name (First, Middle	, Maiden Suman			
ylar	2 should be filed v and Mental Hygie Is marked other t reumatic event, It	To B		Andrew	Steele				E	Elizabeth To	odd		
Mar	12 sho hand 'Isma reuma		19a. Informant's Name/Relation	onship <i>(Type, Print)</i> . Johnston-Dau	ahtar	19b. Mailin			<i>r Rural Route Numb</i> eet, Lonaconi		•		
<u>6</u>	es 1 and of Health f item 27 r other tr		20a. Method of Disposition	. Joiniston-Dau	20b. P	lace of Dispo	sition (Name of natory or other pla		Date	20c. Location -			
Baltimore,			1 Burial 2 Crematic 4 Donation 5 Other		July 21, 2004	July 21, 2004 Moscow Mills, Maryland							
alti	permit. Page Department of Important: If any Injury of		21. Signature of Funeral Servi	ce Licensee	ess of Facility 1-McKenz	ie Funeral Ho	Funeral Home P.A. 8 East Main Street						
ш	20 E 29		Jona E. Ma	Konzie					Lonaconing,				
	Physician /Medical Examiner	Examiner	shock, or heart failure. If Immediate Cause (Final disease or condition resulting in death)		Rem Due to (o	r as a conseq	,				On	inval Between set and Death	
Box 68760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and are director, page 2 should be detached for use as the burial-transit	ledicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d		r as a consequ							
о Ш	ie deal the att hed fo	Physician/N	Part II. Other significant cond	itions contributing to d	eath but not resu	ulting in the ur	nderlying cause given	ven in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death?	
, P.O	res that the des signed by the a I be detached f		Sepsi	S					1	Yes 2 MNo	3 Probabl	y 4 □ Unknown	
of Vital Records,	w requires been sign should be	Completed by	multi	ple m	ini ST	roke.	<u> </u>			an autopsy ormed?	availab	utopsy findings le prior to etion of cause h?	
æ	The la	ШO	ORgan	ue BR.	S WIL	yndi	20 MZ		1 🗆	Yes 2 No	1 □ Ye	s 2□No	
/ita	cien: ertifica ector,	Be	25. Was case referred to med examiner?	cal					Death (Check only	one)			
of	Physion this contained in	5	1 ☐ Yes 2 ☑ No 27. Manner of Death		Inpatient 2 of Injury	ER/Outpatien 28b. Time of	t 3LI DOA		ng Home 5 ☐ Resi 28d. Describe	dence 6 □Oth			
ion	nding ath. r: After	ation	1 □ Natural 5 □ Per	ding (Mon stigation	of Injury th, Day Year)	Injury	28c. Inju Wo M 1	rk? ∣Yes 2∐No		. ,			
Division	To the Hospital or Attending Physicien: The law within 24 brouts after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide		e of Injury - At ho ing, etc. (Specif)		eet, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural Ro	ute Number,	
	Hospit 24 hour Funera tely fills	Medical	(Check only 2 Medic	ying Physician: To the al Examiner: On the b	asis of examinat								
	o the vithin 2 o the omple	Med	one) 29b. Signature and title of cert		ner stated.		29c. Licens	se number		29d. Date signe	d (Month, Day,	Year)	
	⊢≯⊢ŏ		> 5,C	hemes.	no		7)2	563	8	July	19. 2	004	
	6		30. Name and address of pers	on who completed cause	se of death (Item		Print) George	· Creek	RRS.N	Frontlei	ing Mary	land 21532	
	Sta		31. Date filed (Month, Day, Ye		Registrar's Signa	ture	1				J	· ·	

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend Item # 23a,27,28a-f, per ME, G836,10//04 TT

Physicia		IIICIA ICCII T DCL III	ertificate of Death	Reg.	Ma. O O	23648
	n	Decedent's Name (First, Middle, Last) Debra Ann Valerie	Jones		Day Year	3. Time of Death
/Medica	al -	Bebra A. Jonds		JULY 17		_ 0900 A
Examine	er '	a. Facility Name (If not institution, give street and number) 1338 FERRARA DRIVE	4b. City, Town, or Location of Deat ODENTON	h	4c. County of Death ANNE ARU	
Funeral Director	_ i	Social Security Number 6. Sex $^{1}\square$ M $^{2}\square$ F 7. Age (In yrs. last birthday $^{2}15-76-1639$	Months Days Hours Min.	(Month, Day, Ye	9. Birth Cot 1956 Maj	nplace (State or Form Intry) Cyland
2 04	h-	Java Residence of Decedent	ocation			10d. Inside City Lin
sho						1 X Yes 2 □
28a-f show	T	Maryland Anne Arundel Odento		140	000	
Den.	声	0e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
s 23g	E .	1338 Ferrara Drive	21113 . Was Decedent of Hispanic Origin? (S		USA 14. Race - Amer	inn todion
of Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes, 2 No If Yes, Give	1 Yes 2 No Specify:	o Rican, etc.)	Black, White	
lural al Ex	g Di	3⊠Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dec	edent's Usual Occupation	161	o, Kind of Business/li	nductar
"na	Completed	(Specify only highest grade completed) (Giv	re kind of work done during most of wor DO NOT use retired)	rking	7. Kind of Edsiness/ii	ndustry
than than	E .	Elementary/Secondary (0-12) College (1-4or 5+)	sistant Manage		Donalds	Postan
Hygint, I	Ö	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai		restau
ed o	m	Clifton Weston	Ora	a Blake		
mari	၉		ling Address (Street and Number or Ri		ity or Town, State. 7	ip Code)
th ar 27 is trau	1		8 Ferrara Dr. (
Hear em 2		P0a. Method of Disposition 20b. Place of Disp	position (Name of		Location - City or T	
0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		cemetery, cr	ematory or other place) e Memorial 7/	22/04 7		- Ma
Department of the limportant: If ite any injury or ot one one one one one one one one one one	1		e Memorial 7/2	23/04 A	nnapolis	s, Ma.
Depa mpo nny i				s Mortua	rv. P.A.	
	\dashv	Larry 13, Ress MO6 483 23a. Part I. Enter the disease, or complications that caused the death. Do not element to the death.	Wm. Reese & Sor 821 West St. Ar			Approximate
	Exa	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):				
phys the	Medicai	d.				
D 40	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	rery Day Year
by the attending pached for use as	-	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	
igned by the be detached	by				0.45-144	
igned by the be detached	by			240 14600 00	ZAD. WEIG dul	opsy findings avai ompletion of cause
ate has been signed by the page 2 should be detached	Completed by Ph			24a. Was an autopsy performed	prior to co	2 🗆 No
ate has been signed by the page 2 should be detached	Be Completed by	25. Was case referred to medical examiner?		autopsy performed 1 Yes 2 ath (Check only one)	prior to co death No 1 Yes	2 No
ihis ceriiicate has been signed by the al director, page 2 should be detached	To Be Completed by	examiner? 1 X Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpate	ent 3 DOA Other: 4 Nursing H	autopsy performed 1 Yes 2 Ath (Check only one)	Prior to co death No 1 ■ Yes	2 No
ihis ceriiicate has been signed by the al director, page 2 should be detached	To Be Completed by	examiner? 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 2 ER/Outpatient 2 Sea. Date of Injury (Mon. Day Year) 1 Natural 5 Pending	ent 3 DOA Other: 4 Nursing F of 28c. Injury at Work?	autopsy performed 1 Yes 2 □ ath (Check only one) lome 5 □ Residence 28d. Describe how i	Prior to co death No 1 ■ Yes	2 No
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death. ctor: Afler this certificate has been signed by the y the funeral director, page 2 should be detached	Certification: To Be Completed by	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide Hospital: 1 Inpatient 2 ER/Outpating (Mont, Day Year) 28a. Date of Injury (Mont, Day Year) 28b. Time (Mont, Day Year) 28b. Place of Injury - At home, farm, sbuilding, etc. (Specify)	ent 3 DOA Other: 4 Nursing For 28c. Injury at Work? 1 Yes 2 No	autopsy operations at the Check only one of the Check only one of the Check only one of the Check only one of the Check only one of the Check only one of the Check on the Che	prior to cudeathy No 1 Yes 6 X Other (Special Injury occurred) t and Number or Runtate) ara Dr.	2 No (ify) AT SCE
death. ctor: Afler this certificate has been signed by the y the funeral director, page 2 should be detached	Certification: To Be Completed by	examiner? 1 X Yes 2 No 1 Inpatient 2 EP/Outpatient 2 EP/Outp	ent 3 DOA Other: 4 Nursing For Action 1 Nursing For	autopsy of format and the following state (Check only one) and (Check only one) tome 5 Residence 28d. Describe how in the control of the control one of the control of t	prior to cideathy No 1 Yes 6 X Other (Special Injury occurred) t and Number or Runtate) ara Dr. et al.	(fy) AT SCET
in 24 hours after death. he Funeral Director: After this certificate has been signed by the pletely filled in by the funeral director, page 2 should be detached	ertification: To Be Completed by	examiner? X Yes 2 No	ent 3 DOA Other: 28c. Injury at Work? 1 Yes 2 No ath occurred at the time, date and place investigation, in my opinion, death occurred of the control of th	autopsy centermed at the time, date	prior to cideathy No 1 Yes 6 X Other (Special Injury occurred) t and Number or Runtate) ara Dr. et al.	2 No all Route Number, stated. to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 $J_{\mathbf{u}\mathbf{1}\mathbf{y}}^{\mathsf{Month}}$ **Physician** 18. 11:50AM Ella Mae Knight /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday. 5. Social Security Number **Funeral** Months 1 □ M 2 🛛 F 93 218-34-6757 July 24, Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County traumatic evant, the Madical Examiner must be notified at 1 ☐ Yes 2 X No Directo St. Mary's Compton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22358 Bayside Road 20627 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nurse Aid 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Hanson Wathen Ella Pauline Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Elizabeth Farrell/Daughter P.O. Box 242, Compton, MD 20627 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Department of Important: If any injury or `4 ☐ Donation 5 ☐ Other (Specify) July 22, 2004 Bushwood, Maryland Sacred Heart Cemetery 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 270, Leonardtown, MD Approximate Interval Balleen Onset an Dea 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the most shock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest, immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physiclan/Medical nse (IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 ☐ Yes 2 ☐ No 2 No certificate 1 ☐ Yes tha Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3 DOA 1 TYes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 No this Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending investigation 1 🗌 Yes 2 No death. 2 Accident Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 - Homicide 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only one) Medi within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Lo J. of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 4035 Three Notch Road, Hollywood, MD ck Jarboe, MD 20636 Dr. J. Patri s Signature 0 Registrar

			State of Maryla		artment of Health and M		•
			For State Registrar		rtificate of Death		ANDONE OOCEO
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	4 stime of Death
	Physici /Medio		LEONARD DANIEL LEW	IS		JUNE 2	Day Year 9 2004 10:13A M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death
			Frederick Memorial Hospi 5. Social Security Number 6. Sex 7. Age (In yrs	tal . last birthday)	Frederick If Under 1 Year If Under 24 Hrs.	9 Date of Righ	Frederick
	Funeral Director		218-24-2126 1 ¹ X ^{M 2□F} 7	6 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,) Oct. 30,	year) 9. Birthplace (State or Foreign Country) 1927 Maryland
	land		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	ocation		10d. Inside City Limits
	a-f ehu	ctor	Maryland Frederick	hurmon	t		1 ☐ Yes 2 No
	72 hours after death with the Maryland natural, or iteme 23a or 28a-f ehow Alcal Examiline mat be motified at	i Directo	10e. Street and Number 13703 A Catoctin Hollow. Road		10f. Zip Code 21788	100	g. Citizen of What Country? U.S.A.
	deat me 2	Funerai	11. Marital Status 12. Was Decedent Ever in Argued Forces?	J.S. 13.	Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
21215-0036	urs after al', or it	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WW ☐		1 □ Yes 2 ၨ️No <i>Specify:</i>	, , , , ,	Specify: White
50	be filed within 72 hours stal Hygiene. ed other than "natural", event, the Moulcal Exe	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/Industry
121	within iene. than "	idu	Elementary/Secondary (0-12) College (1-4or 5+)	1 -	DO NOT use retired) truction Foreman		.F. Wilson & Sons
d 2	Hygie Hygie other i		17. Father's Name (First, Middle, Last)	COMB	18. Mother's Name		
Maryland	should be filed ind Mental Hygin is marked other umatic event.	To Be	Cyrus Paul Lewis		Edna Kuh	in	
Mar	s 1 and 2 should f Heelth and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rura		
	1 and Heelt em 2		Anna C. Lewis (Wife) 20a. Method of Disposition 20b.		A Catoctin Hollow osition (Name of matory or other place)		hurmont, MD 21788 Doc. Location - City or Town, State
nor	0 ° ± 5				matory or other place) ge: Cemetery 7/2/2		urmont, Maryland
Baltimore,	permit. Pag Depertment Important: any injury c		21. Signatury of Piney I Service Licenses		BERRING Address of Facility &		
ä	permi Depe impo any ir		table . Al	6:	15 EAST MAIN STREE	T. THURM	ONT, MD 21788
			23a. Part1. Enter the disease, or complications to the used the deashock, or heart failure. List only one caus a each line.	ith. Do not ent	ter the mode of dying, such as cardiac	or respiratory arres	t, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	nee	Cardiop	MM	Nary Onset and Death
1	/Medical Examiner		Due to (or as a conse	quence of):	this book +6	yora	29 <12148S
	SUP	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):	our news	asea	SE
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	40	ulmonary;	Horo:	sis
760,	be executed sician and burial-transit		resulting in death) Last Due to (or as a conse	quince on:	/ '	ii ii	
6876	cate b	dicai	d				
9 X	leath certificate ettending phys I for use as the	/Me	IF FEMALE: 23c. If yes, outcome of pregr	nancy			23d. Date of delivery
Box	death s etter d for u	Physician/Medi	in the past 12 months? I Vos 2 Dela 4 Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)		Month Day Year
Ö.	at the de by the tached	hys	9 □ Unknown 9□ Unknown				
of Vital Records, P.	ires the signed I be de	by	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
eco	law requase been	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
R		Corr				performe	death? No 1 ☐ Yes 2 ☐ No
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?			(Check only one)	
of	hys his	L.	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 [27. Manner of Death 28a. Date of Injury	ER/Outpatier 28b. Time of		me 5 Resident	ce 6 Other (Specify)
on	Attending r death. ector: After by the fune	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Work? M 1 □ Yes 2 □ No	200. 0000.00	injury occurred
Division	ii or Attanding P efter death. I Director: After t d in by the funera	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, str	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number,
ā	ital or rs efte al Dir led in	Cert					
	To the Hospital or Attandi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	iowledge, death ation and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
•	To the within To the comp	Me	29b. Signature and title of certifier themen	mo	29c. License number	_	I. Date signed (Month, Day, Year)
	10+1		30. Name and address of person who completed cause of death (Ite	em 23a) (Type,			
			John Harper, MD 400 West Seve 31. Date filed (Month, Day, Year) 32. Registrar's Sign		reet, Frederick, M	aryland 2	21/01
	Sta Registi		JUL 2 2 2004 > Serve	va	& Sparks		
					- MUMAN		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1 Decedent's Name (First, Middle, Last) July 2004^{Year} **Physician** 8, Labin 6:10a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Citizens Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖸 F 97 Yrs. Director 578-10-0805 February 10, 1907 Pennsylvania Usual Residence of Deceden death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Inoppartment of Health and Mantial Hygiene.
Inoportent: If item 27 is marked other than "natural, or items 23s or 28s-f show any injury or other traumatic svent, the Madical Examinat must be notified at 1 ☐ Yes 2 ☐ No Maryland Frederick Frederick Direct 10e, Street and Number 10f. Zîp Code 10g. Citizen of What Country? 1900 Rosemont Avenue 21702 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ¾XNo Specify: \$ Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4or 5+) Piano teacher music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clyde Call Clara Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Junkin - daughter 6256 N. Mayfair Circle, Williamsburg, Virginia 23188----20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3X Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery |7/12/2004 Waynesburg, Pennsylvania 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Homes, P.A. amille UL 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 7/ensine disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The faw requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physicien Physician/Medical es the t attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown been si 1 Yes No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has 2 X No 1 Yes Hospitet or Attending Physician: 24 hours after death. Funerel Diractor: After this certifice director 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) X No 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Deal 28b. Time of 28d. Describe how injury occurred Certification: Natural Injury 5 Pending Accident 3 Suicide 1 🗌 Yes investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as states.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person with mp ted cause of death (Item 23a) (Type, Print) ptreet, Frederick, Maryland 300 West Ninth 21701 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

DI 11411 17 1104 172001

DHMH 17 Rev 1/2001

Registrar

		-	For State Registrar	State of Mar		artment of Health a rtificate of Death		giene Reg. No:2	1 22652
	Physicia		Decedent's Name (First, Middle, La Charles	st)	Mason		2. Date of De Julion 7,		3: Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, giver Frostburg Village		ne	4b. City, Town, or Location of Fros	f Death stburg	4c. County of I	y Y
*	Funeral Director		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday) 79 Yrs.	If Under 1 Year If Under 2 Months Days Hours	Min. 8. Date of Bin	th , ⁷ †924 ^{9.}	Birthplace (State or Foreign
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Allega		10c. City, Town or Lo	cation burg			10d. Inside City Limits 1 ☐ Xes 2 ☐ No
	h with the	Funeral Director	10e. Street and Number 1 Kaylor Circle			10f. Zip Code 21532	2	10g. Citizen of Wha	t Country?
920	72 hours after death with the Maryland naturel; or Items 23a or 28a-1 show dical Exacinet cutt be natified at	by	11. Marital Status 1 Never Married 2 Married 3 Mowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Original of the second of the sec	in? (Specify Yes or No , Puerto Rican, etc.)		American Indian, White, etc. White
Maryland 21215-0036	_	Completed	15. Decedent's E (Specify only highest grant (0-12)		(Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	of working	16b. Kind of Busin Bethleher	
land 2	be filed ntal Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last Charles N. Mas	son			r's Name (First, Middle, cabeth Flore		
	12 sh h and 7 ts m treum		19a. Informant's Name/Relationship (Evelyn Howard	Type, Print) daug	nter 196 Roll	ne 6 Box 6234	r or Rural Rouk Rumb	er City or Town, Sta	te, Zip VVVV 26726
Baltimore,	of Horizon		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci			Cemetery (c) (ace)	Date 7/20/200		
Balt	permit. Pag Department Important: I eny injury o once.		21. Signature of Funeral Service Lice	Y. Scark	all		venue; Cumbe	erland, MD 2	
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Lene cause on each line					Approximate Interval Between Onset and Death
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,0928	cate be executed physician and the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):				
Box 6	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as it	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of Month	f delivery Day Year
rds, P.O.	w requires that I been signed by should be deta	Ď	Part II. Other significant conditions		not resulting in the u	nderlying cause given in Part I.			te to the cause of death?
of Vital Records,		Completed					24a. Was autor perfo	ormed? prior	e autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vita	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatien	t 2 ☐ ER/Outpatie	Other -/	of Death (Check only o		Specify)
	nding Phys th. : After this s funeral di		27. Manner of Death Vatural 5 Pending Pe	28a. Date of Injury (Month, Day	28b. Time o		28d. Describe	how injury occurred	
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funarat Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, lactory, office	28f. Location (. City or To		or Rural Route Number,
	e Hospit 124 hours e Funare letely fille	Medical (examination and/or in	h occurred at the time, date and vestigation, in my opinion, deat			
)	To th withir To th comp	Me	29b. Signature and title of certifier	om	2	29c. License number D2124	44	29d. Date signed (A	Aonth, Day, Year)
	3		30. Name and address of person who Jesus Tan M.I		ath (Item 23a) (Type, Fro	stburg Plaza Fro	ostburg MD	21532	,
	Sta Regist	ate rar	31. Date filed (Month, Dey, Year) JUL 2 2 2004	Server 32. Registrat	's Signature	ads			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. Ng. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 20, 2004 **Physician** 4:15 am Frauline Valeria Marshall /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Neme (If not institution, give street and number) Examiner Harford Jarrettsville 3905 Boxwood Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7 Age (In vrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F 81 Yrs. Oct.14,1922 Maryland 213-16-1715 Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City. Town or Location 10a. State 10b. County 28a-fehow me 23s or 28s-f ehov 1 ☐ Yes 2 TNo Director Jarrettsville Harford MD the 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number MICH 21084 USA 3905 Boxwood Road death Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) lteme 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify. Ā 3 AWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Henry Smith Hester Wareheim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3905 Boxwood Road, Jarrettsville, MD 21084 Health a Beth Rogers Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pagas 1 Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St.Paul's Cemetery July 25,200 Millers, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J. J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 Xous ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use by each line. 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final PER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner mt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760 attending physicien Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 20 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 2 No 1 Yes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Yo 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the ft 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 10 LONG-CORNER RUAN WHITE HAHIMD AT CAVILLMID Į State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 20 2004 1735 July Margie Elinor Mackie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Elkton Union Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 20, 192 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F Marýland 84 Director 222-05**-**9482 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a, State 10b. County "naturai', or Items 23a or 28a-f show adical Exat∴iner must be notified at 1 ☐ Yes 2 No Elkton Directo Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 650 Lewisville Road 21921 United States Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: à White 3 ⊠ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Complet ntal Hygiene. ed other than "r event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Horse Racing and Mental Hygier is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna Peterson Norman Burke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau once. 150 Carters Mill Road, Elkton, Maryland 21921 John C. Mackie, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 24, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sharps Cemetery $200\bar{4}$ Fair Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a.ACUTE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and as the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2.2 No the funeral director. Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 1 ☐ Impatient 2 ☐ ER/Outpatient 20 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Natural 5 Pending investigation 1 🗀 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D29221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary NEU W. 57 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 4:40P M Ju₁y Marjorie Ann Martin 10 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 23490 Maddox Road Chaptico St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F Director 412-40-5538 22, 1930 Louisianna Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumetic event, it a Medical Event ar must be mailthed at 1 ☐ Yes 2 No Director Maryland St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23490 Maddox Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Mamed 2 Marned Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12th illed Horse Breeder Eguine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fauld Mental F Charles Noble Churchill Mildred Pearl Britt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iit. Pages 1 and 2 sixtment of Health an ortent: if itam 27 is 1 2566 Babcock Road, Vienna, Virginia 22181 Daniel F. Dozier / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Importent: If any injury o 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield - Echols July 14,2004 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature Funeral Service Kilo 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death hot enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Due to (or as a greequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed the attending physicien and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 Do
9 Unknown Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown signed by 1 d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Lakmown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 16 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 700 Other: 1 Tes 1 Inpatient 2 ER/Outpatient 2 3 DOA 4 ☐ Nursing Home 5 Sidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 0 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and addr of person w completed cause of death (Item 23a) (Type, Print) Boyd M.D. James 23415 Three Notch Road California, Maryland 20619 31. Date filed (Month, 32. Registrar's Signature State Registrar

ncgrath, Joseph J

68760,
P.O. Box
Records,
of Vital
Division

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 2004^{Year} July **Physician** 8, 3:12 PM Joseph Donald McGrath /Medical 4c. County of Deeth Charles 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner La Plata, MD Civista Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** Days 1☑M 2□F Months Hours 76 Yrs. September 17,1927 Washington D.C. Director 578-30-7204 Usual Residence of Decedent e filed within 72 hours efter death with the Maryland of Hygiene. other than "naturel, or flems 23s or 28s-f show 10d. Inside City Limits 10c. City. Town or Location 10a. Stete 10b. County Department of Health and Mentel Hygiene important: or Items 23e or 28s-f sho important: if Item 27 is marked other than "naturel", or Items 23e or 28s-f sho important: if Item 27 is marked other than Madical Examiner must be notified at pine. 1 ☐ Yes 2 🔀 No Directo Maryland St. Mary's Coltons Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20345 Dukeharts Court 20626 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus Black, White, etc. 1 XYes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 2 Specify: Year or Dates: 1946 - 1947 White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 D.C. Public Works Supervisor D. C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Peges 1 and 2 should be fil ment of Health end Mentel H tant: If item 27 is marked ott Lawrence Staniclaus McGrath Florence Lavonia Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Lucile McGrath/Wife 20345 Dukeharts Court, Coltons Point, Maryland 20626 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Buriet 2 □ Cremation 3 □ Removal from State 2004 4 ☐ Donetion 5 ☐ Other (Specify) Charles Memorial Gardens July 14. Leonardtown, Maryland 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A., P. O. Box 270, 21. Signature of Funeral Service bice Leonardtown, Maryland 20650 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final XIVIC disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner XWICS Mill attending physicien end for use es the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Sie Til, MECITA certificate be Physician/Medical Due to (or as a consequence of): requires that the deeth Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the a 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 20 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? The law 1□ Yus 2 200 1 ☐ Yes 2 ☐ No after death.

Director: After this certificete of in by the funerel director, pag Attending Physicien: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 ☐ Pending investigetion 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ō To the Hospital or within 24 hours att To the Funerel Di completely filled in rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) SPE 20624 rson who completed cause of death (Item 23e) (Type, Print) then, MD 11345 Pembrooke Square, #103 Waldorf, MD 20603 30. Name and address of person who cleorge wathen, 31. Date filed (Month, Day Year)

DHMH 16 Rev 6/95

State

Registrar

32. Registr's Signeture

1 2 2004

			For State Registrar	State of M	Maryland	•	artment <i>rtificate</i>			and M	• •	giene	004	23658
	Physici /Medi		1. Decedent's Name (First, Middle, La David Robert Mattin								2. Date of Dea Month July	Day	Year 2004	3. Time of Death 2:05 A.
	Examir		4a. Fecility Name (If not institution, giv 22985 Abell Street				4b. City, To Leonar	dtown	n			St.	County of Death Mary's	
	Funeral Director		5. Social Security Number 6. S 217-68-8404 1	ex 7. A	Age (In yrs. Ia 47	Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da) August 6	y, Yeer)		place (State or Foreigr Intry) Land
	the Maryland 28a-f show cuified at	ector	10a. State 10b. County Maryland St. Mary! 10e. Street and Number	5		Town or Lo	cation	ode				10g Citiz	en of What Cou	10d. Inside City Limits
336	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if health and Mental Hygiene. Item 27 Is marked other than "natyel", or Items 23s or 28s-f show other traumatic event. The Medical Examinant be redifficated.	by Funeral Director	22985 Abell Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 F If Yes, Give Year or Dates	s? ₹No		206	50 nt of His y Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	US		ican Indian, , etc.
1215-0036	within 72 ho ane. than nater se Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1.2	ducation ade completed) College (1-40	r 5+)	(Give life. l	dent's Usual kind of work DO NDT use Driver	Occupa done di retired)	tion uring most	of worki	ing		d of Business/Ir	
Maryland 21	ould be filed whental Hygie arked other after event.	To Be Co	17. Father's Name (First, Middle, Last, James Maguire Mattin		ŀ	Truck	Driver				e (First, Middle, Edwards		sportatio	on
Baltimore, Man	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other than 'any injury or other traumatic event. Ite Maones.		19a. Informant's Name/Relationship (Mary Ann Mattingly/I 20a. Method of Disposition 1	Nother Removal from States	e 20b. Pla	22985 Anace of Disposite Aloysit	Abell Sistion (Name natory or oth	treet of er place tery Address	Leon	nardte C uly li	own, Mary Date 2,2004	land 20c. Loc Leona	rdtown, M	own, State
	And provided and p	cal Examiner	23a. Paxf. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to minimal disease. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hunder a Due bloor a Due to (or a C. Mu fa	line.	ence of):					e fun		wes	Approximate Interval Between Onset and Death
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal of dea	death 3□	Ectopic pred Other (spec					2	3d. Date of deliv Month	ery Day Year
ecords,	law requires that nas been signed b e 2 should be deta	Completed by Ph	Part II. Other significant conditions of	contributing to death	but not resul	lting in the u	nderlying cau	ise give	n in Part I.		24a. Was autop	es 2	No 3 Prol	the cause of death? bably 4 Unknown popy findings available popletion of cause of
of Vital	Attending Physiclen: The law r death. ector: Atter this certificate has by the funeral director, page 2.9	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Statural 5 Pending 2 Accident investigatio			ER/Outpatien 28b. Time of Injury		Othe	r: 4 □ Nui	rsing Hor	(Check only of	2 No na) lence 6	Other (Special	2 🗆 No
Division	i Dir	Il Certification:	3 Suicide 6 Could not be determined	building,	etc. (Specify)				a data as		City or Tow	n, State)		al Route Number,
j	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical		nysician: To the besininer: On the basis and manner	of examination	on and/or in	vestigation, in	n my op	number	h occurre	ed at the time, o	date and p 29d. Date	and manner as solace, and due to signed (Month,	o the cause(s)
			30. Name and address of person who Dr. John F. Fenwick.	St. Mary's	Medica	1 Arts		ıg, L	eonard	ltown,	, MD 2065	0	/	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 12	2004 32. egis	strar's Signatu	B A	house							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2004 6:55 p.m. Pollyanna Cook Ju1y 6. /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 42509 Shady Pine Court Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 ■ F Yrs. 2. 1920 Missouri Director 488-12-2039 83 Sept. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location an "natural", or Items 23a or 28a-f ahow Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42509 Shady Pine Court 20650 United States Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: þ 3 BWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental Lilyan Brown Sherwood Isaac Thompson Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Itam 27 is
any injury or other trau Pamela Melin Coflin/ Daughter 43426 Drumcliff Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 7-9-2004 Charlotte Hall, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. David A. Goff M01095 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Pert1. Enter the disease, or cololly tions the cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only cause on a line. Immediate Cause (Final disease or condition resulting in death) **Physician** ine /Medical Due to (or as a construence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): lan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Physic by the a 9☐ Unknown 9 Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy oerform certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: ပ 1 Yes 25 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) After the 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation М 1 Tes 2 No the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 455751 7/7/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Schmidt, D.O., 23415 Three Notch Road, California, Maryland 20619 Jennifer 32. Resistrar's Signature 31. Date filed (Month State

DHMH 17 Rev 1/2001

Registrar

3altimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

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			1 - For State Registrar AMEND ITEM	State of Ma		-						giene	04	236	60
	Physici	an	1. Decedent's Name (First, Middle, Last, Katherine Ann Ner)	0000	1120	04 0				2. Date of Dea Month July 7	ith	Year	3. Time o	f Death
	/Medio Examin		4a. Facility Name (If not institution, give				4b. Çity	Town, or	Location of	of Death	oury /		ounty of Dea		Pivi
	LXGIIII	CI	Montgomery Genera	al Hospita	1			01:	ney			M	lontgo	merv	
	Funeral Director		5. Social Security Number 6. Sec. 217-30-0637	7. Age	(In yrs. last 72	birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth June 14			rthplace (State of ountry) nnsylvar	or Foreign nia
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside C	in a la
	Maryla f sho	ō	Maryland Montgom			ney	oation								2 No
	r 28a-	rect	10e. Street and Number				10f. Zi	Code			1	10g. Citize	n of What C	ountry?	 -
	th with	ai D	17648 Prince Edwa	ard Drive			2	0832					USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 A Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates:		11	Vas Dece Yes, spe	cify Cuba	ispanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		Race - Am Black, Whi	erican Indian, ite, etc. White	
21215-0036	in 72 ho n "natur Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed)		6a. Deced (Give	lent's Usu kind of wo	rk done o	during mosi	t of worki	ing	16b. Kind	of Business	s/Industry	
212	giene giene er tha	Com	12	College (1-4or 5+	•}	Med	ical	Ass:	istan	t		Phys	ician	's Offi	ce
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yla	Ment Ment Marke Marke	<u>o</u>						l			mmerman				
, Maryland	and 2 sh salth and n 27 is m er traum		19a. Informant's Name/Relationship (Ty John S. Garofolo/				-				German				
altimore,	Pages 1 ent of He nt: If itan		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place ceme	Gate	of F	ther place leave	n		y 10,			Town, State	vland
Balti	permit. Pag Department Important: any Injury		*4 Donation 5 Other (Specify) 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Fur 500 University Blvd.												_
			23a. Part1. Enter the disease or compl shock, or heart failure. List only or	ications that caused the cause on each line	he death. [Do not ente	or the mod	le of dying	g, such as	cardiac o	r respiratory arm	est,		Approximat Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	Hapo	yole	enl	~ 5							Onset and I	Death
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	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Qeel	Encol	live	140	un!	3 1	Disc	480				
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8760,	cate b	dicai		d											
.O. Box 6	The law requires that the death certifi ste has been signed by the attending r page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal dea	ath 3 🗌	Ectopic p Other (sp					23d	. Date of de Month		rear .
Φ.	that the ed by detac	Ph	Part II. Other significent conditions cor	ntributing to death but	not resultin	g in the un	derlying	ause give	en in Part I.		23e. Did tob	pacco use	contribute to	o the cause of d	eath?
rds	n sign	d by									1 □ Y€	s 2 □ N	lo 3 🗆 P	robably 4	nknown
Vital Records,	s been si	Completed									24a. Was a		4b. Were a	utopsy findings a	available
æ	The lav	mo									autops perform	ned?	death?	completion of ca 2 No	ause of
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of	S S	2	1 ☐ Yes 2 🗭 No	fospital: 1 Minpatient		Outpatient			4 🗆 140		ne 5 Reside			ocity)	
uc	ding Phy h. After thi funeral	tion	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day		b. Time of Injury	M	8c. Injury Work	at :? ∕es 2.∐1		28d. Describe ho	w injury o	ccurred		
Division	Attano deati octor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home	, farm, stre			105 2		28f. Location (St	reet and N	umber or Ri	ural Route Numi	ber.
2	al or / s after I Dire	Serti	4 Homicide	building, etc.	(Specify)		.,				City or Town				
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the funer	edical (29a. Certifier 1 Certifying Physical Control 2 Medical Examination	sicien: To the best of ner: On the basis of e and manner state	examination	dge, death and/or inv	occurred estigation	at the tim	e, date and pinion, deat	d place, a	and due to the ca ad at the time, da	ause(s) and ate and pla	d manner as	s stated. e to the cause(s))
	within To th	Me	29b. Signature and title of certifier	11		·		. License						h, Day, Year)	
)	13		I Un Con	14				3 C	108	20	39	71-	2104		
			30. Name and address of person who so Matthew Connolly,				-	o Dr	. #22	5; 0	lney, MI	208	32		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature			nks.							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:40 PM ARUNEE NIYOMSUIS 07 03 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PACK, MACYLAND ADVOUTIST HOSPIPAR TAKOMA WASHINGTON Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 3, 1938 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F None Thailand Director 66 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exercitor coust be notified at Thailand N/A Nakornpathom 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 76 Napra Road N/A Thailand or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or iten any injury or other traumatic event, the Medical Exercities. Once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pakdee Kijprayoon 2 Uraiwan Srisooksai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saravuth Niyomsub/ Husband 79 Napra Road, Nakornpathom, Thailand 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 7, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Métropolitan 2004 * 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia Crematory 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee Md 20901 23a. Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only and cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COLONALY ALTERY DISMASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 physicien Physician/Medical use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ŏ Day Year Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by KONAC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient မ 1 Yes 2 No 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and tyle of certifier out al-Cen MA 0 50590 TAKENIA PACK CAlune, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE CALLOLL Scutt 400 7601

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

06

32. Registrar's Signature

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	Physici /Medi		Decedent's Name (First, Middle, Las. Thomas G. Ow								2. Date of De Month July		2004	'ear	3. Time of 0	
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	Funeral Director		5. Social Security Number 6. Sec	X 7. Ag	ge (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under 24 Hours	Min.	B. Date of Bi (Month, Do Oct.5,	191	7 Wa	Birthpla Count Shir	ace (State or ry) igton, I	Foreig C
	Maryland -f show	tor	10a. State 10b. County Maryland Montgome	ry		y, Town or Lo thersb								10	d. Inside City	
	r 28a	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of Wha	at Count	ry?	
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36	i within 72 hours after death with the Maryland liene. r than "natural", or Itams 23a or 28a-f show The Medical Examinar must be molfiled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:			Was Deced If Yes, spec		spanic Origin n, Mexican, F Specify:	n? (Spec Puerto R	ify Yes or No ican, etc.)	0-	14. Race - Black, Specify: \(\)	White, e	tc.	
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Maryland 21215-0036	9 E 0 5	To Be	17. Father's Name (First, Middle, Last) Claude Worthingto		Sr.				Emma	Sch						
Nar	CA 40 = 40		19a. Informant's Name/Relationship (T	ype, Print) (Son)					nd Number o .rcle -				or Town, Sta	ate, Zip (Code)	
	1 and Health em 27 thar t	1 9	20a. Method of Disposition	(3011)	20b. P	lace of Dispo	sition (Nan	ne of	1	Da			Location - Cit	ty or Tow	vn. State	
2	permit. Pages Department of I Important: If its any injury or of		1 XBurial 2 Cremation 3 🗆		0	_{emetery, crei} k1awn	natory or o	ther place		-7-04			kville			
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=	or Atten tter deal iractor; n by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	ury - At ho c. (Specify	ome, farm, str	-				f. Location (City or To		nd Number o	or Rural I	Route Numbe	<u></u> ∋r,
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			> Purcellaco	ellatar	ua	m)	Do	11794			Ju	ly 2,	20	04	
	1211		30. Name and address of person who co	ompleted cause of c	leath (Item	23a) (Type,	Print) Russ	æll	Ave	Ga	ithers		g, M0			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jeannette Mindel OKIN July 4, 11:30 P M 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Potomac Montgomery Manor Care Potomac Months Days Hours Min. July 18, 1916 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months New Jersey 1 ☐ M 2 🔀 F 87 Yrs 141-07-1369 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County rthan "netural", or items 23a or 28a-f show the Medical Examinar mant be nutified at 1 ☐ Yes 2 👿 No Rockville Directo Marvland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 United States 1 Olmstead Court by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: white 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' ury or other traumatic event, the Mu College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bessie Ruben Irving Klieger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 Olmstead Court, Rockville, MD <u>Eric Okin, Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1V Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden 07/06/04 permit. Page Department o Importent: If eny Injury or Falls Church, VA 21. Signature of Funeral Social Törcninskystebyew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ding IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed page 2. No After this certificate funeral director, pag 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27, Manner of Death Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by hours after 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO057/24 eno, un n 5/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, M.D., 13219 Executive Park Terrace, Germantown, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 7 2004 Registrar

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Registrar

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	1	For State Registrar	State of Maryland / Dep Ce	ertificate of Death	vieritai mygiei Reg. i		22000		
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/Medic Examin	al -	Ma. Fecility Name (If not institution, give s	ary Levia Pilkerto: treet and number)	4b. City, Town, or Location of Death	July 14	2004 4c. County of Death			
_ Xuiiiiii	Ŭ.	St. Mary's		Leonardtown			t Marys		
uneral irector		5. Social Security Number 6. Sex 1215-34-6860	M 2 ☐ F 7. Age (In yrs. last birthda) 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea April 30, 1		nplace <i>(State</i> or Fore <i>Intry)</i> Maryland		
_		Usual Residence of Decedent	10c. City, Town or	ocation			10d. Inside City Lim		
show	5	10a. State 10b. County					1 ☐ Yes 2 🔯		
28a-f	Director	Maryland Saint M 10e. Street and Number	arys	Mechanicsvill 101. Zip Code		Citizen of What Co	untry?		
23a or	<u>=</u>	27930 Scrav	eltown Lane	20659		USA	A		
other than "natural", or flems 23a or 28a-1 show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U.S. 13 Armed Forces? 1 ☐ Yes 2 ☒ No	l. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	e, etc.		
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other than '	Com	Elementary/Secondary (0-12) 7	College (1-4or 5+)	School Bus Contracto		School Trai	nsportation		
d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maid	en Sumame)			
item 27 is marked of	J.	A1 to	n Monroe Ouade	iling Address (Street and Number or Ru	Lucy Cather				
27 is r traur		Mildred Susan Tippet		, , , , , , , , , , , , , , , , , , , ,		Maryland 20656			
item (20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place)		Location - City or			
ant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)		Heart Cemetery July	17, 2004	Bushwood,	Maryland		
Important: If any injury or once.	2 1	21. Signature of Funeral Service Lisens	96	22. Name and Address of Facility Mattingley-Gardi P.O. Box 270 Leo	ner Funera	1 Home, P MD 20650			
			cations that caused the death. Do not a			.m 20050	Approximate Interval Between		
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attending p	0	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of deli	ivery		
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ate h	Som				performed 1 ☐ Yes 2 ☐		2 🗆 No		
certific	Be	25. Was case referred to medical examiner?	Hospital:	Others	ath (Check only one)	0 5000 (0	-16.1		
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ath. r: Afte te fune	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injur	y Work? M 1 ☐ Yes 2 ☐ No					
Directo in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, larm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S.		ıral Route Number,		
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Co	29a. Certifier (Check only one) Certifying Phy 2 Medicel Exem	sicien: To the best of my knowledge, do ner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and plac investigation, in my opinion, death occ	e, and due to the causiurred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)		
within To the	Me	29b. Signature and title of certifier		29c. License number		Date signed (Monti			
2,50) SC Gal	75 M.D.	D 5434	6	7/14/	04		
			ompleted cause of death (Item 23a) (Type		d 3/- d	4 20020			
		01	lra Sajja, M.D. 24035 T	nree Notch Road Holly	wood Marvlar	ia 20636			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 28, 2004 4:30 a.m. Richard June Pearson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 21475 Williams Drive Lexington Park
If Under 1 Year | If Under 24 Hrs. | 8, Date St. Mary's 8. Date of Birth (Month, Day, Year) April 25,1939 Akron, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Min. Director 284-34-4928 65 Ohio Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show other traumatic avent, the Middled Examiner trust be notified at 1 ☐ Yes 2 XNo Director 28a-f MD St. Mary's Lexington Park 10e. Street and Number 10g. Citizen of What Country? 238 21475 Williams Drive Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 V Yes 2 No 1956—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12th Machinist DynCorp. Pages 1 and 2 should be filed nent of Health and Mental Hygi nnt: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Milton Pearson Dorothy Gehm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21475 Williams Drive Lexington Park, MD 20653 Margery Lou Pearson (WIFE) Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition July 1, 2004 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. • 4 □Donation Brinsfield-Echols Crematory 5 Other (Specify) Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signaturj Lightsee David A. Goff MO 1095 22955 Hollywood Rd. Leonardto shock, or heart fairue. List only one cause on each line. Immediate Cause (Final disease or conditions) 22955 Hollywood Rd. Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death METASTATIL HEAD ENELL CANCEP Physician 12 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed attending physician and tor use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached to P.O. | 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should be 2 No 3 Probably 4 □Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 NO uneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home SPResidence 6 Other (Specify) 1 Yes 2 No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Atter 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) De De D50600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 RC GURDEEP .S. CHHABRA, ST MART'S HOSPITAL, LEONARD TOWN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 0 2 2004

32 Registrar's Signature

			1 - For State Registrar	State of M	aryland /		artmen rtificat					Reg	ne 	September of the septem	2366	8
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Las Rosa Herminia P	ineda							2. Date of D Month July		2004	Year	3. Time of t	Death a.M
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036	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or Items 23e or 28e-1 ahow event, the Medical Exam or mutter routhly at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔼 If Yes, Give Year or Dates:		į.	Was Deced If Yes, spec				cify Yes or N Rican, etc.)	io-	14. Race Blace	e - Amend k, White, Whit		
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Baltimore,	permit. Pages 1 a Department of He Important: If itan any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		20b. Place came Ga	tery, cres te of Ceme	sition (Nan Patory or o Heav etery	ven	ŀ	20		Si		Sprin	ng, Mar	
Balt	permit. Pag Department Important: It any injury o		21. Signatury of Funeral Service Licen	Of-		50 50	ranci O Uni	d Address S J. Vers	s of Facility COLI ity E	ins.	Funera	311	Home I ver Sp	nc, ring	, MD 20	0901
	Physician /Medical Examiner		23a. Part 1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Card	a consequence	Car lu		e of dying	g, such as o	cardiac o	r respiratory	arrest,			Approximate Interval Betwo Onset and De	een
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8760,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or s	a consequence	oe of):										
.O. Box 6	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea]Ectopic pro] Other (sp						23d. Date Mon		ry Day Ye	9ar
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Division of	ding h. After fune	ertification; T	27. Mann of Death 1 Vatural 5 Pending investigation	28a. Date of Inju (Month, Day		Time of Injury	M 28	Bc. Injury Work 1 Y		2	8d. Describe				/	
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	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phyone) 2 Medicel Exem	vsicien: To the best of iner: On the basis of and manner sta	examination :	lge, death and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deatl	d place, a h occurre	nd due to the id at the time,	date	e(s) and mar and place, a	ner as stand due to	ated. the cause(s)	
)	within To the Comp	W	29b. Signature and title of certifier The Late	Hun.	170			License					Date signed			
			30. Name and address of person who co	completed cause of d	eath (Item 23a		Print)	4	Ac	Che	uy Ch	aff	ous	204	3/5	
	Sta		31. Date filed (Month, Day, Year)	32. Degistra	ar's Signature	9	don	els	/		1					

Pineda, Rosa 7/3104 6356 AM

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 2:00 A **Physician** July 1, 2004 Perdigao /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Potomac Montgomery Manor Care If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 93 Hours 1 □ M 2X F 026.14.0747 1911 Plymouth, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Bethesda MD Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20817 9405 Seddon Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates: ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury of other treumetic event once. Be Fred Thomas Mary Diaz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9405 Seddon Road Bethesda, Maryland Jean Giaudrone/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) §\) Vine Hills Cemetery July 7, 2004 Plymouth, MA 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Coneral Service Licensee 5130 Wisconsin Avenue NW Washington DC 20016 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months **Physician** Cachexia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** months Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Due to (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 1 detached 9 Unknown 9 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dementia page 2 should Be Completed been Artherosclerosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 3 No Physicien: director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Hospitel or Attending 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide filled in within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 2, 2004 D31319 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Avenue Suite #103 Bethesda, MD Loreto Albiol, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 06 2004 Registrar

			State of Maryland / [Department of H Certificate of L			ene a. N. () () ()	23570
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	0.00	3. Time of Death		
	Physicia		Fanny Peiper	July 5	, Day 2004 Year	9:15 pM		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Death	
			Manor Care Wheaton	Silver	Spring		Montgomor	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	Months Days	Spring Funder 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	year) 9. Birthr	lace (State or Foreign
	Director		077 00 1700	Yrs.		Feb 6 19	009 Pola	nd
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location			1	0d. Inside City Limits
	Mary -f shu	ţo	Maryland Montgomery Silve	r Spring				1 □ Yes 2 → No
	r 28a	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Cour	ntry?
	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Modical Examinat must be notified at	al D	1135 Loxford Terrace	20901		Į	J.S.A.	
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec n, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Americ Black, White,	
36	s afte	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Λ Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify:	
Ş	hour turel			. Decedent's Usual Occupa	ation	10	Whi 6b. Kind of Business/In	~~
5	in 72	Completed	(Specify only highest grade completed)	(Give kind of work done a life. DO NOT use retired,	durina most of workin	g	DD. KING OF DUSINGSOM	dustry
212	d with giene. ir tha	E O	Elementary/Secondary (0-12) College (1-4or 5+)	hotographic	Retoucher		Photograph	У
9	be filed within 72 hours after death with the Marylan tal Hygliene. Id other than "naturel", or litems 23a or 28a-f show or other than "naturel", or litems 23a or 28a-f shown, the Medical Extending must be notified at	Bec	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
<u>a</u>	should b and Ments marked umatic e	2	Moses Alster		Elka Dwo	jra Find	der	
Maryland 21215-0036	2 should be filed v n and Mental Hygie 'Is marked other t reumatic event, III		19a. Informant's Name/Relationship (Type, Print) 19b	o. Mailing Address (Street a	and Number or Rural	Route Number,	City or Town, State, Zip	Code)
ر ک	1 and 2 Health Iem 27 other tra			.135 Loxford of Disposition (Name of				
altimore,	S = 1		1 Burial 2 Cremation 3 Removal from State	ry, crematory or other place	e) .T117.v		Dc. Location - City or To	own, State
Ħ	permit. Pag Department Importent: I eny injury c		· abortanon · o a o mon (oposity)	politan Crem			lexandria,	Virginia
Ba	permit. Departr Importe eny inj		21. Signature of Funeral Service Licensee	Francis Addes				
			23a. Part1. Enter the disease, or complications that caused the death. Do					q, MD 20901 Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	~				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or a consequence	of):				
	Examiner							100
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or in itry)	of):				
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80,	cate be executed physician and the burial-transit		Due to (or as a consequence	01):				
8760	physi physi the b	dlcal	d					
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ğ	seath atter	ciar	in the past 12 months? 1 Yes 2 No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
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ď.	res thai igned to be det	by P	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause give	en in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
ğ	w require been sig should b	edt	tuyler tension			1 🗆 Yes	2 No 3 Prob	ably 4 □Unknown
Records,	has bei	Completed	Alzenevis Dementa			24a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of
	The ate his page	Com				performe	ed? death? No 1 ☐ Yes	
Vita	cien: ertific actor,	Be (25. Was case referred to medical examiner?		26. Place of Death			
7	hysio this co	ို	1 ☐ Yes 2 ☐XNo Hospital: 1 ☐ Inpatient 2 ☐ ER/O				ce 6 □Other (Specif	y)
Division of	ilng F	lon;	1 □Natural 5 □ Pending (Month, Day Year)	Time of Injury Work	/ at 21 √? Yes 2 □ No	8d. Describe how	injury occurred	
<u>s</u>	death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa			Bf Location (Stre	eet and Number or Rura	I Route Number
<u>></u>	lor A after Direction by	Certificat	4 Homicide determined 236. Place of Injury - Al home, to building, etc. (Specify)	ann, street, ractory, onice	100	City or Town,		, riodio ramboi,
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledg	e, death occurred at the tim	ne, date and place, ar	nd due to the cau	ise(s) and manner as s	ated.
	ne Ho ne Fu netely	edical	(Check only one) 2 Medicel Exeminer: On the basis of examination are and manner stated.	nd/or investigation, in my op	oinion, death occurre	d at the time, dat	e and place, and due to	the cause(s)
	To the within To the Comp	Ž	29b. Signature and title of certifier	29c. License	number	290	d. Date signed (Month,	Day, Year)
	12			DOC	58962	Ju	ıly 6, 2004	
	1 -		30. Name and address of person who completed cause of death (nem 23a) Shashank G. Patel, M.D. 2309 Sm	(Type, Print) profield Dri	ve, Wheato	on, MD 2	0902	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	5 Sparks				
X	Regist	ar	JUL 08 2004 June /	- japones				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** ROXANNA LANE POWELL JULY 11:10 P M PALMER 16 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1101 CHURCH HILL ROAD CENTREVILLE QUEEN ANNE'S II Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Yrs Director 222-01-3218 88 JAN. 1916 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD QUEEN ANNE'S CENTREVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Herns 23e 1101 CHURCH HILL ROAD 21617 USA death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2 XNo fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No þ Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced Year or Dates: "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME Pages 1 and 2 should be filed nent of Health and Mental Hyginant: if item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HOWARD S. LANE MAE PALMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROYDEN NATHAN POWELL, III/SON 1460 SPANIARD NECK ROAD, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 0 = 0 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or CHESTERFIELD CEMETERY 7-21-2004 * 4 ☐ Donation 5 ☐ Other (Specify) CENTREVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service License once. fenlan 408 S. LIBERTY ST., CENTREVILLE, MD 21617 uma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tion **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760 Physician/Medical detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Yea 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, page 2 should be 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 20 No 1 Yes 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending s after de. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a pe lii Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certifier Physician 29c. License number 29d. Date signed (Month, Day, Year) HO057821 Waman use of death (Item 23a) (Type, Print) 30 Name and address of person who comple entreulle; MO Centre 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

		1	For Stete Registrar	State o	f Maryland		irtment of H tificate of	lealth and N <i>Death</i>		iene eg. No. 00	4 23672
			Decedent's Name (First, Middle	, Last)					2. Date of Deat	h	3. Time of Death
	Physicia	_	Clifford John Qui	nn					Month July	05 200	Year 04 6:40 A. M
1	/Medic Examin		4a. Facility Name (If not institution		mber)		4b. City, Town, o	r Location of Death		4c. County of	
	CXamili	er	Calvert Memorial				Prince Fr	ederick		Calve	rt
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)		If Under 24 Hrs.	8. Date of Birth (Month, Day,	Voar) 9	9. Birthplace (State or Foreign Country)
	Funeral Director		323-26-9262	1 M 2 □ F	81	Yrs.	Months Days	Hours Min.	Dec. 02,		Missouri
			Usual Residence of Decedent								101111110001111
	ylan		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	a Ma	ţ	Maryland St. Mar	y's	Cali	Eornia					1 ☐ Yes 2 No
	7 28 D	lre.	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wh	at Country?
	filed within 72 hours after death with the Maryland Hygiona. Inther than "naturelt, or Items 23s or 28s-f show ant, the Madical Examinar must be notified at	Funeral Directo	22826 Old Rolling				20619			USA	
	dea dea	ner	11. Marital Status	Armed F	edent Ever in U. prces?		Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		- American Indian, White, etc.
9	or It	F	1 Never Married 2 Marr	ied 1 ∇Ves If Xes, G	2 □ No Ve Pates: 1952-19	954	1 ☐ Yes 2√√No	Specify:		Specify:	White
Ö	ural',	d by	3XXWidowed 4 □ Divorced		ates:		death Henry Occur	nation		16b. Kind of Busi	
21215-0036	72 h	Completed	15. Deceden (Specify only highe	t's Education st grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of worl	king	TOD. KING OF DUST	nessindustry
7	han han	ďш	Elementary/Secondary (0-12)	College	1-4or 5+)					Retail Sa	100
7	lled v lygie her t		17. Father's Name (First, Middle,	l ast)		Custon	er Service	T	ne (First, Middle, I		
JE .	be finds the finds of the finds	Be						Univnov	Two.		
Ž	d Mer nark natic	ဥ	Unknown 19a. Informant's Name/Relations	hin (Type Print)		19b. Mailir	ng Address (Street	Unknow and Number or Ru		: City or Town, St	tate, Zip Code)
Maryland	12 sl h and 7 is r traur		Ava Mae Kopp/Daugh					Lusby, MD			
e,	1 and Heall em 2 ther		20a. Method of Disposition	ter	20b. P	lace of Dispo	sition (Name of			20c. Location - C	ity or Town, State
و	ages or or or		1 ☑ Burial 2 ☐ Cremation		State	-	natory or other pla	1	06 200/	Toonandtar	· m MD
Ħ	rtmer rtant rtant		* 4 ☐ Donation 5 ☐ Other (S		Cliai		norial Gard 2. Name and Addre		06,2004	Leonardtov	VII, PID
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inproprient: If item 27 is marked other than "natural; or Items 23a or 28a-f show myoriant: If item 27 is marked other than "natural; or Items 23a or 28a-f show may injury or other traumatic event, the Madical Examinar must be notified at any injury or other traumatic event, the Madical Examinar must be notified at ange.		21. Signature of runeral service	*		Ma	ttingley-G	ardiner Fun	eral Home,	P.A., P.	O. Box 270,
			23a. Pert1. Enter the disease, o	complications that	caused the deat			MD 20650 ng, such as cardiac	or respiratory arr	est,	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Met	istatic	POOY	TY Diffe	enenciat Car	ed Non.	-Smalla	e// 1 west
	Examiner			Due to	(or as a conseq	dence or).		Car	cinom	a.	
		e.	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conseq	uence of):					
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_6	al-tra	Examin	that initiated events resulting in death) Last	CDue to	(or as a conseq	uence of):					
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687	ficate p phy ss the	edical									
Вох	leath certifica attending ph	Z	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna		75-4			23d. Date	
ă	atte	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2□Feta nant at time of d		⊒Ectopic pregnanc ∃ Other <i>(specify)</i> _			Mont	h Day Year
P.O.	res that the de signed by the a be detached to	nysi	9 Unknown	9□Unk	nown						
	that ned b deta	by PI	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	inderlying cause g	ven in Part I.	23e. Did to		oute to the cause of death?
ds	puires n sign	g D	Thrombo	ytoper	19				1 🗆 Y	es 2□No 3	Probably 4 Monknown
00	w requir been si should	lete	Dement	170					24a. Was a	an 24b. We	ere autopsy findings available ior to completion of cause of
of Vital Records,	The lay	Completed	H2180210		Heart	dic	ease		autops perfor	med? de	eath?
ā	ilcian: Th certificate rector, pag	ပိ	25. Was case referred to medical		1 ewit	415	eusc.	26. Place of Dea	ath (Check only or		
<u>=</u>	Physician: rthis certificaral director, pr	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA	hon	lome 5 ☐ Resid		(Specify)
	ding Physicia J. After this cer funeral direct		27. Manner of Death		of Injury oth, Day Year)	28b. Time o				ow injury occurred	
on	th. : After s funer	to	1 ☑Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Mo igation	nin, Day 18ai)	Injury	M 10	Yes 2□No			
Division	or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	e of Injury - At h	ome, farm, st	reet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
Ö	2 = C	Certification:	4 Homicide	, Buil	uling, etc. (Specif	y /			., ., ., .,	.,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certify	ng Physician: To the	e best of my kno	owledge, dea	th occurred at the	ime, date and place	a, and due to the curred at the time	ause(s) and man	ner as stated. nd due to the cause(s)
	n 24 n 24 ne Fu	edical	one)	and ma	nner stated.	ation and/or ii	ivestigation, in my	opinion, death occu			
	To the Tro the Tro the Comp.	×	29b. Signature and title of certifi	(_	A 24 A			ise number	2	-	(Month, Day, Year)
			leyan		ana.			50653			2004.
	10100		30. Name and address of person			п 23а) (Туре	Print) GYF	1N-C-5	URAN	A	- A
	UN		5851. Dec		schoon	Roo	d.	Deale	mP.	207	15/
		ate	31. Date filed (Month, Day, Yea	7 2004 32	egistrar's Signa	ature	Goods				
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		-	For State Registrar MFND#18, 19ape						nd Mental Hy	giene Reg. No.	004	23673
	Physici	an	Decedent's Name (First, Middle, Las JENNIE	s.		ROOT			2. Date of De Month JULY		2004 [°]	3. Time of Death 6:00a M
Ī	/Medic Examin	er	4a. Facility Name (If not institution, give Arden Courts	street and number) Manor C	are	ast birthday)	4b. City, Town, o	tomac	Death	4c. C	ounty of De	eath ITGOMERY Birthplace (State or Foreign
ì	Funeral Director			M 21/20 F	90	Yrs.	Months Days		Min. 8. Date of Bin (Month, Date of Bin Dec. 28	iy, Year) 3,191		Country) Penn.
	Maryland 8-f show	ctor	10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits 1 ☐ Yes 25 No
	h with the	ai Director	10e. Street and Number 11025 Rosemo:	nt Drive			10f. Zip Code	2085	52	-	U.S.	
36	rs after death I, or Items 2	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ▼No If Yes, Give Year or Dates:			1	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2점 No		n? (Specify Yes or No Puerto Rican, etc.)		Black, W	merican Indian, hite, etc. White
1215-003	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23a or 28a-f show ther then medical Experiment must be indiffied at	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)				dent's Usual Occu kind of work done DO NOT use retire	during most of du	of working		Bb. Kind of Business/Industry Department Store	
Maryland 2121	uld be filed v Aental Hygie rked other t tic event, tb	To Be Co	12th Departm 17. Father's Name (First, Middle, Last) Alvin Shenenberger 18. Mother's Name (First, Middle, Maiden Sumame) Globle Katie Cibbs									
	and 2 shousalth and Masser 18 mail	19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Constance Connie R. Long (Daughter) 11025 Rosemont Dr., Rockville, MD										
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may july or other traumatic event, the Madical Experiment and be notified at once.		20a. Method of Disposition 1 ☑ Burjat 2 ☐ Cremation 3 ☐ 4 ☐ Displation 5 ☐ Other (Specification 5) 21. Signature of Funeral Service Licentee) //	0	emetery, crer ch Fu		Iome 7		Manh FUN	eim, ERAL	HOME, P.A.
	Pnysician /Medical		28a. Part1. Enter the disease, or come shock, or heart failure. List only immediate Caust (Final disease or continuous disease or continuous disease)	Due to (or as	el	Do not ent					<u> </u>	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a conseq	uence of): erte	Mio	1				months
Box 68760,		Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcome						23	d. Date of	delivery
o.	that the death led by the atter detached for r	hysicia	Fait ii, Other significant commoding to death but not resulting in the underlying cause given in 1 at 1.								Day Year	
rds, P	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by									e to the cause of death? Probably 4 Anknown	
Vital Records,		Completed							24a. Was auto perf 1 🗆 Yes		prior t death	autopsy findings available to completion of cause of ? es 2 \(\begin{align*} \begin{align*} \begin{align*} 2 \begin{align*} \begin{align*} \begin{align*} 2 \begin{align*} \begin{align*} \begin{align*} 2 \begin{align*} \begin{align*} \begin{align*} 2 \begin{align*} \begin{align*} 2 \begin{align*} \begin{align*} \begin{align*} 2 \begin{align*} \begin{align*} \begin{align*} 2 \begin{align*} \begin{align*} 2 \begin{align*} \begin{align*} 2 \begin{align*} \begin{align*} 2 al
Vita Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ED/0-4	O1 001	The second second second	of Death <i>(Check only</i> sing Home 5 Res		DO# (0	
of	ding h. After fune	tion; To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, Da	ury	28b. Time o Injury	f 28c. Inju		28d. Describe			респу)
Division	i di di	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In building, e	iury - At h	ome, farm, st	reet, factory, office			(Street and wn, State)	Number or	Rural Route Number,
	Hos Fun ely	edicai			of examina				place, and due to the n occurred at the time			
	To the Vithin 2 To the Complet	Me	29b. Signature and title of certifier	au				se number 35792				onth, Day, Year) , 2004
		ř	30. Name and address of person and Swaroop G.	mpleted cause of Rao, M.I		п 23a) (Туре, 50 W.	Print) Edmons	ton D	r., Rock	ville	e, MI	20850
	, St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ature	Some	. /.				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 0930 M CHAMBERLIN KEDMOND **Physician** MXXINE 5 U 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner #194 Silver Mont POMERY 3102 Hewill If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🛛 F May Kansas Director 579-07-7949 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 23a or 28a-f show il Hygiene.
other then "natural", or Reme 23e or seer some orther then "natural", or Reme 23e or seer some orther the Medical Exercities of the matthe natural and a remember of the Medical Exercities of the matthe and the matthe an 1 ☐ Yes 2 No Funeral Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3102 Hewitt Avenue United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene Importent: If them 27 is marked other then "natural; or iten any injuryor other traumatic event, its Medical Exercising 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ð 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Purchasing Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Chamberlin Louise Shumard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2151 Jamieson Avenue, #1011, Alexandria, VA John F. Redmond/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition July 6, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐Donation 5 ☐ Other (Specify) 2004 Brentwood, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signatul of Funeral Service Linesee Rockville, Inc. M00803 Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ♠No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2**/2** No 2 🗆 No 1 Yes 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) 12Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1/2 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npletely filled in by 4 Homicide Joint 24 hours after To the Funerel Direct Tc, the Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 000 1000428 m Dim E FOCE on earcart 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER MO parks) mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_		1 - For State Registrar AMEND#26perM. 1. Decedent's Name (First, Middle, I	D7/9/04,BMW		•	artment of I			2. Date of De	Reg. No	004	23675
	Physician /Medical Stephanie J. Rakowski Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death								Month Day 7-4-2004 4c. County			11:50 A.M	
F	uneral irector		Casey House 5. Social Security Number 6 153-12-7018	. Sex 7. 1 □ M 2 ☑ F	Age (In yrs.	last birthday) Yrs.	Rockvil If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da 12-26-		ontgome 9. B	ry irthplace (State or Foreign Country) PA
the Maryland	the Maryland 28a-f show	rector	Usual Residence of Decedent	mery		y, Town or Lo	caster L	ane –	Silv		ing	lizen of What (10d. Inside City Limits 1 ☐ Yes 2 ☐ No
5-UU36 72 hours after death with the Maryland	ral', or items 23a or Examiner musi be	Completed by Funeral Director	13419 Doncaste: 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deced	es? ☑ No					ecify Yes or No Rican, etc.)	U.S	A. 14. Race - An	nerican Indian,
nd 21215-0036 e filed within 72 hours af Il Hygiene.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or frems 23a or 28a-f show any injury or other traumatic event, the Markinal Evant or invatice inclined at once.	Be Completer	15. Decedent's (Specify only highest statementary/Secondary (0-12) 12 17. Father's Name (First, Middle, La	grade completed) College (1-4	lor 5+)	(Give life. I	dent's Usual Occu kind of work done DO NOT use retire	during mos		ng (First, Middle	Ow	n Home	s/Industry
Maryland of 2 should be file th and Mental Hy	77 is marked traumatic ev	To B	m										
altimore, rmit. Pages 1 an	ortant: If itam injury or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service ↓	cify)	ate C	Place of Dispo emetery, crem e of H	sition (Name of natory or other pla eaven Ce Name and Addre	ca) m.	7-8-2	2004	20c. Lo	ocation - City o	
G Peg C	lmpo any i		23a. Part1. Enter the disease, or co	emplications that can	shed he deat	× 11	800 New	Hampsl	hire	Ave. S	ilve		Approximate Interval Between
/M Exa	physician and edical sthe burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Gangr Due to (or b. Perip Due to (or c. Diabe	ene as a conseq heral	vascul us.cs off. 11itus	as disea	se					Onset and Death Month Years Years
death certif	ed by the attending phy detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2∏Feta nt at time of d	Ideath 3□	Ectopic pregnanc	y				23d. Date of de Month	alivery Day Year
ecords, P.O.	been signed b should be deta	by	Part ii. Other significant conditions contributing to dealin but not resulting in the underlying cause given in Part I.										
r ag	ate has page 2	e Completed	25. Was once referred to medical							1 ☐ Yes	osy rmed? 2 X No	24b. Were a prior to death?	
2 E	After this funeral di	ToB	examiner? 1 Yes 2 X No Hospital: Repairent 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										ecity) Hospice
or A after	aral Director: illed in by the	l Certification;	3 Suicide 4 Homicide 6 Could not determine	ed 286. Place of building	, etc. (Specif	y) 	eet, factory, office			City or Tox	vn, State)	Rural Route Number,
To tha Hospital within 24 hours	To tha Funaral Direct completely filled in by	Medical	(Check only one) 2 ☐ Medical Ex	Physician: To the basiner: On the basiner and manne	is of examina r stated.	wieage, death tion and/or inv	occurred at the ti restigation, in my of	pinion, dea	d place, a	ed at the time,	date and	and manner a I place, and du e signed (Mon	e to the cause(s)
	7		30. Name and address of person wh	? Lu		23a) (Type		9470		The state of the s	7-	-5-2004	
			Eugene P. Lib:		10400		•			ngton,			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:40 P^M 2004 LAWRENCE JOSEPH RAUNER JULY 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CAROLINE RUXTON HEALTH OF DENTON DENTON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 88 Yrs. PENNSYLVANIA Director 164-05-3058 SEPT.11,1915 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show In Deliffed at 1 ☐ Yes 2 ▼No MD TALBOT **EASTON** Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 9 23a or 12 PARK LANE 21601 USA death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status the Madical Examinar n filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No. Specify: WHITE þ 3 X Widowed 4 □ Divorced "naturei" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 4 **SALESMAN** FURNITURE RETAIL marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Hy Important: If item 27 is marked oth sny injury or other treumatic event QNCs. JOSEPH RAUNER DEHLIA KELLY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHEILA BEESON/P.O.A. 1133 BOYD ROAD, STREET, MD 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY | 07/14/2004 | STEVENSVILLE, MD 21. Signature of Funeral Service Licenses permit. FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. P.m.1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No cate has been significant category. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

32. Registrar's Signature

2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 07:25 AM Harry Robert Spiker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heart Hospita Allegan socred rolascin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□F Maryland Yrs. 217-28-0556 May 26, 1932 Director 72 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director Frostburg Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 **USA** 15401 Lower George's Creek Road S.W. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 10 Roll Wrapper Westvaco Paper Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Agnes Fazenbaker Harry Spiker ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15401 Lower George's Creek Road S.W., Frostburg, Maryland, 21532 Alice Gay Spiker/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park July 18, 2004 Cumberland, Maryland ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 E. Main 21. Signature of Funeral Service License St., Lonaconing, Md.21539 23a. Part1. Enter the disease, or complications that cau: —the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on part line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as 3 o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 유 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3□ DOA this Manner of Death Certification: 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No after death in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) () ype, Print) DR. Shin Kim 90 Main street WESTERNPORT, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 9:40 a.m. Cecelia Somerville July 2004 Catherine /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 F Yrs. 78 May 18, 1926 Maryland Director 220-18-7231 Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location e filed within 72 hours after death with the Marylan al Hygiene, is other than "natural", or Iteme 23a or 28a-1 show yent, Ite Madical Examinant aust be notified at 1 ☐ Yes 2 PNo Directo Loveville Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 24305 Dellie Lane 20656 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 ∰ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 6 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 School Bus Contractor Transportation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be f permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic avonce. is marked Joseph Dellie Somerville Susie Ann Frederick ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph Blaine Somerville, Jr./Son P.O. Box 82, Loveville, Maryland 20656 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7-7-2004 Queen of Peace 4 ☐ Donation 5 ☐ Other (Specify) Helen, Maryland 22. Name and Address of Facility $Brinsfield\ Funeral\ Home,\ P.A.$ 21. Signature of Funeral Service License MO David A. Goff 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Type II Diabetes and the burial-tran Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No ò 4 Pregnant at time of death 5 Other (specify) Yes P.O. ed by the detached 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown Hypothyroidism, Hypertension, Spinal Stenosis, 1 ☐ Yes 2 No 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an Chronis Renal Insufficiency certificate has autopsy page 1 Yes 2 0 No Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 \(\tau \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 25 No ER/Outpatient 3□ DOA Certification; To this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. uneral Director: ₽ the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the ... within 24 hour... To the Funeral D' critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D0055682 attending 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas M. Wilkinson, M.D., 23415 23415 Three Notch Road, Suite 2052, California, MD 20619 31. Date filed (Month, Day, Year) State 8 2004 Dans Registrar

		,	1 - For State Registrar			nd / Depa	artment c		and M	ental Hygi		16.	236	79
	Physici /Medic		1. Decedent's Name (First, Middle, L Kathryn H. Sper	•						2. Date of Death Month July 3		Year	3. Time of D 2:00	Death PM
*	Examin	er	4a. Facility Name (If not institution, go Wilson Healthcar		oury Vi			n, or Location of hersbur	g	G Data of Birth		gomer		
	Funeral Director			1□M 2 0 F	7. Age (In yrs. 85	Yrs.		ays Hours	Min.	8. Date of Birth (Month, Day, July 31,				
	e Maryland le-f show lifted at	ctor	10a. State 10b. County Maryland Monto	jomery	10c. Ci	ty, Town or Lo Potoma						10d.	. Inside City 1 ☐ Yes 3	
	be filed within 72 hours after death with the Maryland tial Hygiene. dother than "natural", or items 23a or 28e-f show event, the Medical Examinar must be notified at	Funeral Director	10617 Stable Lar 1. Marital Status 1 Never Married 2 Married	T	2X No						Black	,	Indian,	
21215-0036	nin 72 hours in "naturel", in "naturel",	Completed by	3 Mode 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) However the specify.											
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E Bai	Dermit Depar Impor any in		21. Signature Fulleral Service Lice 23a, Part1. Enter the disease, or co) J.C	ole	50	00 Univ	ersity	Blvd	Funeral W., Si	lver Sp	ring,	MD 2	0901
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Betwee Onset and Deat Showur.											
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on of Vital	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Chatural 5 Pending investigate	28a. Date (Mon	Inpatient 2 Coordington	28b. Time of	28c.	0 4	rsing Hom	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 2	iminer: On the p	asis of examina ner stated.	ation and/or in	estigation, in r	ny opinion, date and my opinion, deat	J place, at th occurre		se(s) and mann and place, an	d due to the	a cause(s)	
	3		J. H. R. West,						5	LLAVEI UKE N		-		
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Í	Sta Registr		JUL 0 6 2	004	Epera	19	done	41						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** July 5, 2004 7:12 P. Charles David Spangler /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number **Funeral** 1**∑**M 2□F Director Feb. 20, 1912 Illinois 92 259-60-7352 Usual Residence of Decedent 10c. City, Town or Location Silver Spring 10a. State 10b. County 10d. Inside City Limits rel', or Items 23a or 28a-f ehov Examiner must be notified at Maryland Montgomery 1 ☐ Yes ZXXNo Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 U.S.A. 10212 Brookmoor Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates: Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) then Public Health Services Sanitary Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) portant: If item 27 is marked of y injury ocother traumatic even Be 2 Mary Adona Evinger Charles H. Spangler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10212 Brookmoor Dr., Silver Spring, MD 20901 John J. Spangler / son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2004 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility permit. Francis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician pneumonia /Medical resulting in death) Due to (or as a consequence of): Examiner stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exam attending physicien and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes, hypertension Completed certificate has lirector, page 2 Be မ Medical Certification:

or Attanding Physician: The law requires that the death certificate be executed Box 68760, P.O. I Division of Vital Records, within 24 hours after death

To the Funeral Diractor:
completely filled in by the To the Hospital

Baltimore, Maryland 21215-0036

_							24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \sum Yes 2 \sum No				
	Was case referred to medical		26. Place of Death (Check only one)									
	examiner? 1 ☐ Yes 2 ☐ N	lo	Hospital: 1 populationt 2	☐ ER/Outpatient	3□ DOA	Other: 4 Nursing I	Home 5 ☐ Residence €	3 □Other (Specify)				
	Manner of Death 1 Natural 2 Accident	5 Pending investigation		28b. Time of Injury	28c.	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred				
	3 🔲 Suicide 4 🔲 Homicide	6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec		, factory, of	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
298			ysician: To the best of my kr niner: On the basis of examin and manner stated.					and manner as stated. place, and due to the cause(s)				

Di

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd., Silver Spring, Maryland 20910 Hien Nguyen, M.D.,

State Registrar

31. Date filed (Month, Day, Year) 07 2004

naugur 41

29h Signature and title of certifier

32. Registrar's Signature

Dacker

29c. License number

DOO57510

29d. Date signed (Month, Day, Year) 7/6/200

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	Physicia	an	Registrer 1. Decedent's Name (First,		•	0 - 4 - 1			01 2		2. Date of	f Death	Day Year 2004	3. Time of	
	- /Medic	al	4a. Fecility Name (If not ins			. Smith	ı, Jr.	4b. City, T	own or l	ocation o		Ly 2	, 2004 4c. County of Death	2:00	A ^M
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mol	Pages ent of nt: If it		1 ☐ Burial 2 ☒Crem 1 ☐ Donation 5 ☐ Ot			State	cemetery, cr ntgomery	matory or other Cremat) J	uly 9, 004	Ве	thesda, M	aryland	1
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturet", or Items 23a or 28e-1 show any niury or other traumatic event, It is Maritial Examiliational Legislibel at once.		21. Signature of Funeral S	ervice Licen	see	мос	198	22. Name and Lobert 00 West	Address A. P	of Facility	rey Funer		Home/Rockv ville, MD 2		
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	/Medical Examiner		resulting in death)		Due to	(r as a conse	quence of):	ANTE	RU	d	ISEASE			i a Sia	25
	P =	ner	if any, leading to immediat cause. Enter Underlying Cause (Disease or injury	8	Due to	(or as a conse	quence of):		/	0(,	0-75-			9 7	
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Funeral Director

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DIVISION OF VITAL DECORDS, P.O. DOX 00/00	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Be Completed by Physiclan/Medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	Sc. If yes, 1 Liv 4 Pri 9 Ur tributing to
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/Medical Examiner	_	a. Facility Name (If not institu		reet and nu	ımber)			4b. City,	Town, or	Location	of Death			1	y of Death		
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uneral		5. Social Security Number	6. Sex	M 2⊠F	7. Age (In	yrs. last b 72	irthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of (Month)	Day,		9. Birth	place (State o	r Foreign
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ent,	1	17. Father's Name (First, Midd	lle, Last)			•				18. Moth	er's Nam	e (First, Mic	idie, M	aiden Suma	me)		
rked tic ev		John Histon								Mar	gare	t For	d				
auma auma	Г	19a. Informant's Name/Relation	onship (Typ	e, Print)		19	b. Mailir	ng Address	(Street a	ın <i>d Numb</i> ı	er or Rur	al Route Nu	mber,	City or Town	, State, Zi	p Code)	
n 27	-	Richard S. Sh	ultz/	Husba												1and 20	0854
O g ii	12	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	on 3∐Re	moval from	State	ob. Place Galle	of Dispo erv, erer O T	sition (Nai Heave	ne of ther place n	θ)	Ju1y	6,	2	0c. Location	- City or T	own, State	
in y o		*4 □ Donation 5 XOther	(Specify)	Entombn			terv	Maus	soleu	ım	2004		L	Silver	Spr	in, M)
Importent: If item 27 is marked other than "natural; or items 23e or 28e-1 show any injury or other traumatic event, the Medical Exeminar must be notified at once. To Be Completed by Funeral Director		21. Signature of Funeral Servi	cellicense	• 	4. MC	0803	Ro Ro	Name ar OCKVI OCKVI	d Addres 11e, 11e,	is of Facili Inc. Mary	300 Land	West 208	. Mo 50-	umphre nt ome 2805	ery A	neral l venue	dome/
		23a. Part1. Enter the disease shock, or heart failure. I	or complication	ations that cause on	each line.	death. Do	not ent	er the mod	le of dying	g, such as	cardiac	or respirato	y arres	st,		Approximate Interval Bet	ween
sician	1	Immediate Cause (Final disease or condition	a	CHI	CONIC	- 0	B57	TRUC	TIVE	Pu	LMO	NARY	· D	ISEA.	35	Onset and I) Sairi
edical miner		resulting in death)		Due to	(or as a cor											U	
44		Sequentially list conditions,	b.		(or as a cor	requence	a of):				-						
isit Jine		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	Due to	(or as a cor	isequence	9 OI):										
ial-transit		that initiated events resulting in death) Last	c.	Due to	(or as a cor	sequence	9 of):								-		
ysician e buria cal E	Ì																
	-		J.												1		
r use		IF FEMALE: 23b. Was decedent pregnant	23		utcome of problems		th 3[∃Ectopic p	regnancy						ate of deliv	-	1000
Tby the attending presented for use as it		in the past 12 months?		4□Preg 9□Unkr	nant at time	of death	5 [Other (se	ecify)					M	onth	Day 1	/ear
d by Jetach		9 □Unknown Part II. Other significant cond	litions cont			t recultina	in the	ndettuna	ause aus	an in Part I	ı	230 1	id toba	ICCO USE COT	Itribute to	the cause of d	eath?
signe d be of	ľ	Malus his	Son	Dear	alsra	+	LHE	Ky.	1 *	5 Pa	of		Yes			bably 4 □l	
house	4	Na Due 1	110	1	1	هن.	Can	0	7 1	1				7		7000	
te has been s age 2 should ompleted	. 1	secondary T	V	UTHI	ng mi	2014	14,	1450	ne			a	Vas an utopsy erform			opsy findings ompletion of c	
r, pag	<u> </u>											1 □ Ye	s 2	No		2 No	
s certif directo o Be	-	25. Was case referred to med examiner? 1 ☐ Yes 2 No		spital:	Innetie=*	م ال	anima:		Othe	ar-		h (Check or		3	has 10:	4.1	
arthis aral di	1	27. Manner of eath		28a. Date		28b.	Time of		8c. Injury	at	ursing Ho			ce 6 ⊡Ot vinjury occu		TY)	
fune Itlor		1 Natural 5 ☐ Per 2 ☐ Accident inve	nding estigation		nth, Day Yea		Injury	М	Work	(? Yes 2□	No						
al Director: After ed in by the funeral Certification:		3 Suicide 6 □ Co	uld not be ermined		e of Injury		tarm, str	eet, factor	y, office						ber or Rur	al Route Num	ber,
Jert Sert		4 D Homicide		build	ding, etc. (S _l	эвсту)						City of	Town,	Jiai8)			
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com		29a. Certifier (Check only one)	fying Physical Exemin	er: On the	e best of my basis of exa- nner stated.	knowledg	ge, deat and/or in	h occurred vestigation	at the tim , in my op	ne, date ar pinion, dea	nd place, ath occuri	and due to red at the tir	the cau	use(s) and m e and place,	anner as : and due t	stated. to the cause(s)
compl	1	29b. Signatur, and title of cer	e ier	/	0.			29	c. License	number			29	d. Date signe	ed (Month,	Day, Year)	
2		Heun 1	UK	and	Sa.	M	0		294	153	,		1	Ules	2,	2004	
8	1	30. Name and address of pers	MAL S	mpleted cau	se of death	(Item 23a) (Type,	Print)	GRO	LE I	es s	ROCKU	12	* U	0 2	08.0	5
State	1	31. Date filed (Month, Day, Ye	ear)	32.	Registrar's S	Signature	1116				-	-,	-		V	- 2 4	
Registrar		THE O	6 2004	1 /	exerces	/	y	ppo	uln								

DFIMH 17 Rev 1/2001

			For State Registrar	State of Maryland		artment of H		-	giene Reg. NØ.	22600
	Physici	an	1. Decedent's Name (First, Middle, Last)	Sheinberg				2. Date of De Month		
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or OLNEY	Location of Death		4c. County of D	eath
	Funeral Director		Social Security Number		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da 08/14/	th 9. I	Sithplace (State or Foreign Country) INSYLVANIA
	d within 72 hours after death with the Maryland jiene. In then "neturel", or Items 23e or 28e-1 show in then "neturel" or Items 23e or 28e-1 show then Medical Exercities matter rectilised at	Director	10a. State 10b. County MARYLAND MONTGOMER 10e. Street and Number	XY SILV	Town or Lo		16		10g. Citizen of What	10d. Inside City Limits 1 X Yes 2 □ No Country?
980	ours after death rel', or Items 23 Examiner musi	by Funeral	15 100 INTERLACHEN 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	DRIVE #7UI 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba			U.S.A. 14. Race - A Black, W Specify:	merican Indian, Ihite, etc. WHITE
Maryland 21215-0036	d within giene. r than "	Completed	15. Decedent's Edu- (Specify only highest grade Elementary/Secondary (0-12) 1 2		(Give life. L	tent's Usual Occupa kind of work done of DO NOT use retired RAM COORD	luring most of worl			ss/industry P ORGANIZATION
yland	0 2 0 0	To Be	17. Father's Name (First, Middle, Last) MORRIS	STERN			FLOSSIE		Maiden Sumame) MAR	
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke sny injury or other trsumstic once.		19a. Informant's Name/Relationship (Ty, MARC SHEINBERG/SON 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	N 20b. Pla	600 M ce of Disponetery, crem	•	OK DRIVE		er, City or Town, State R SPRING, 20c. Location - City FALLS CHU	MD 20905 or Town, State
Baltir	permit. F Departme Importer sny injur		21. Signature of Funeral Service License Umanda		22 FT	Name and Addres	s of Facility	AL DIREC	CTION, INC	•
8760,	Cate be executed / Medical Examiner : the burial-transit	dical Examiner	23a. Part1. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):		g, such as cardiac	or respiratory at	rrest,	Approximate Interval Between Onset and Death DAYS
.O. Box 6	at the death certifii by the attending F tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	3c. If yes, outcome of pregnand 1□Live birth 2□Fetal d 4□Pregnant at time of dea 9□Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
Δ	es that gned b	by	Part II. Other significant conditions cor		ing in the ur	nderlying cause give	on in Part I.			e to the cause of death? Probably 4 Unknown
al Records,		Completed	25. Was case referred to medical					1 ☐ Yes	prior to the prio	autopsy findings available to completion of cause of ? es 2 \(\sum \) No
ion of Vital	Attending Physicien: Traeath. r death. ector: After this certificat by the funeral director, pa	atlon; To Be	examiner?	lospital: 1 X Inpatient 2 El 28a. Date of Injury (Month, Day Year)	R/Outpatien 8b. Time of Injury	28c. Injury Work	at	ome 5 Resid	dence 6 Other (S,	pecify)
Division	tel or Attenders after deatles by Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	ledical	onej	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	edge, death n and/or inv					
)		Z	29b. Signature and title of certifier	MD		29c. License D1872			29d. Date signed (Mo	
	15		30. Nume and address of or rson who co ARTHUR SCHOENGOLD	, M.D., 18111	PRINC		DRIVE, O	LNEY, MI	20832	
	Sta Registi	-	31. Date filed (Month, Day, Year) JUL 0 8 200	32. Registrar's Signatu	J J	South	/			

		-	For Stata	State of	Marylan	•	artment of H		nd Mental		000		00001
			Ragistrar 1. Decedent's Name (First, Middle	la Last)		Cei	tilicate of L	Jean	2 Date	of Death	g. No.	14	3. Time of Death
	Physici		Jennifer	Nicole	Shan	ık			July			Year	8:30 AM
	/Medic Examin		4a. Facility Name (If not institution	n, give street and num	nber)		4b. City, Town, or	Location of	Death		4c. County o	f Death	
			94 Barrensda	le Dr.			Severna	Park			Anne A	rund	le1
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mon	of Birth th, Day, 1	Year)	9. Birthp Cour	lace (State or Foreign
	Director		216-02-3650 Usual Residence of Decedent		27	115.			May	9, 1	9// 5	outh	Carolina
	/land		10a. State 10b. County		10c. City	, Town or Lo	ocation					1	0d. Inside City Limits
	Many a-f sh	ξ	MD Anne	Arunde1	Sev	erna l	Park						1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of W	nat Cour	ntry?
	ath w		94 Barrensda				21146				USA		
36	be filed within 72 hours after death with the Maryland tial Hyglene. id other than "natural", or items 23a or 28a-f show event, I're Medical Extrainer cast by notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	ned 1 ☐ Yes	2∭ No e	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🔯 No	spanic Orig n, Mexican, Specify:	in? (Specify Yes Puerto Rican, e	or No-		, White,	
Ş	hour			nt's Education	1100.	16a, Dece	dent's Usual Occupa	ation		16	6b. Kind of Bus	iness/Inc	dustry
215	nin 72 In "ne Medik	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)	-40r 5+)	(Give life.	kind of work done of DO NOT use retired	during most)	of working				,
21	d with giene er tha	E O	Elementary/Secondary (0-12)	College (1-	401 54)	Accou	ıntant				Govt. C	ontr	acting
nd	2 should be filed and Mental Hygi is markad other aumatic evant, II	Be	17. Father's Name (First, Middle,						's Name (First, M		aiden Sumame)	
S	should be and Mental s marked o	၉	John R. Phill	-		4.0h	- Add (Charata		oerta Eg		0 % T		0-1-1
Ma	s 1 and 2 should f Health and Men itam 27 is marks other traumatic	ΠĬ	Jason Allen S		hand)	1	ng Address <i>(Street a</i> Barrensda)						146
ō,	Tan Heal tam 2		20a. Method of Disposition	nank (nus	20b. P	lace of Dispo	sition (Name of		Date		Oc. Location - C		
OL.	ages ant of nt: If i		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (5		STATA I	-	matory`or other plac itan Crema		7/7/04		Alexand	ria,	VA
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If itam 27 it any injury or othar tra		21. Signature of Funeral Service	1			2. Name and Addres						es
	v - · · ·		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that ca	aused the death							-	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition			Vat	From (r Mini	N			+	Onset and Death
	/Medical		resulting in death)	a.	or as a consequ				/			1	monik
	Examiner		Sequentially list conditions,	b									
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):							
	icate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last	cDue to (or as a consequ	uence of):							
8760,	sician sician burit	dicai E											
9	tificate g phy as the	0										1	
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and to as should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		inth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)			_	23d. Date Mont		ny Day Year
<u>a</u>	uires that signed b	by	Part II. Other significant conditi	ons contributing to de	ath but not resu	ulting in the u	nderlying cause give	en in Part I.	23e	. Did toba 1 ☐ Yes			e cause of death? ably 4 □Unknown
Vital Records,	The law require sate has been sin page 2 should b	Completed								Was an autopsy performs	pri de	or to cor ath?	osy findings available npletion of cause of
/ita	Physician: T this certificat ral director, pe	Bec	25. Was case referred to medica examiner?						of Death (Check				
of V	Physical this call dire	၉	1 ☐ Yes 2 ☑ No	-		ER/Outpatier		4 🗆 Mui	sing Home 5				′)
n C	ling F. After une	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	'9	of Injury h, Day Year)	28b. Time o Injury	Work	rat <br Yes 2.⊟N		cribe how	r injury occurre	1	
Division	deat deat tor: the	lcat	3 Suicide 6 Could		of Injury - At ho	ome farm sti	reet, factory, office	195 2 N	_	tion (Stre	et and Number	or Rura	I Route Number,
Div	after after Direct d in by	Certification;	4 ☐ Homicide determ	buildir	ng, etc. (Specif)	()	oot, tastory, omoo			or Town,			
	To the Hospital or I within 24 hours after To the Funeral Directorpletely filled in b	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the Examiner: On the ba and mann	sis of examinat	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	ne, date and pinion, death	d place, and due th occurred at the	to the cau time, dat	ise(s) and man e and place, ar	ner as st	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifie	er 1	/	<u> </u>	29c. License	number		290	d. Date signed	Month, I	Day, Year)
	10		1/	BVF	~ M)	100	513	01	J	14	4	204
	(0		30. Name and address of person		e of death (Item	2)	Print) SUPE 300,	An	napolis,	MO	210	14	
	Sta Registi		31. Date filed (Month, Day, Year JUL 09	2004 32.8	egistrar's Signa		Sparks	/					

		4	For State	State of	Maryland / Depa	artment of H			0.001	00000
			Ragistrar 1. Decedent's Name (First, Middle, La	ct)	06/	tillcate of	Deain	Rag. 2. Date of Death	No.	3. Time of Death
	Physici			,					Day Year	
	/Medic		LILLIAN R. SPIVAC		nber)	4b. City. Town, o	r Location of Death	JUNE 29,	4c. County of Dea	9:40 A ^M
	Examin	er	CASEY HOUSE	0 01.001 2.12 112.11	,	ROCKVILI		1	MONTGOME	
	Funeral			Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	thplace (State or Foreign
	Director		465-03-3495	1□M 2\\F	84 Yrs.	Months Days	Hours Min.	(Month, Day, Ye 11/02/19)	19 GAL	ZESTON, TX
	P.		Usual Residence of Decedent							7
	arylar show	_	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits 1 Yes 2 No
	Ba-f	Director	MARYLAND MONTGOME	RY	POTOMAC	T				41
	with th		10e. Street and Number			10f. Zip Code			Citizen of What C	ountry?
	a 23	Funeral	9004 WANDERING TR			2085			. S . A .	orioan Indian
	Item Item	Ę.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed For	ces?	If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	Rican, etc.)	Black, Whi	
36	Ir. or	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	9	1☐ Yes 2X No	Specify:		Specify: [HITE
21215-0036	d within 72 hours after death with the Maryland Jene r than "naturel", or ltema 23e or 28e-f show The Medical Evarinat must be natified a		15. Decedent's E		16a. Dece	dent's Usual Occup	ation	166	. Kind of Business	/Industry
215	. 2 30	pie	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-	life.	NING of work done of DO NOT use retired	during most of workii d)	ng		
21	e filed within Il Hygiene. other then vent, the Me	Completed	12		SECRET	ARY		M'	r. SINAI	
nd	be filed ntal Hygid of other event, I	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Mail	den Sumame)	
Maryland	2 should be and Mental Is marked raumatic ev	ို	HENRY	MAS	SSIN		ESTHER		GREENFI	ELD
Nar	2 sh and 1s m		19a. Informant's Name/Relationship		1		and Number or Rura		•	
e)	and Health In 27 Der t	1 3	SHELLEY BRODECKI / 20a. Method of Disposition	DAUGHTE	R 9004 20b. Place of Dispo		G TRAIL DE	-	DMAC, MD Location - City or	
ŏ	S = 50		1 X Burial 2 ☐ Cremation 3 C		State cemetery, crei	natory or other plac	ce)			
Baltimore,	rtmer rtent njury		 *4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice 			CEMETERY 2. Name and Addre		/2004 SC	DLON, OHI	.0
Ba	permit. Pages 1 and 2 should be Dep riment of Health and Menta Importent: If Item 27 is marked any nijury or other traumatic events.		1 amanda	Ruda	ira E	DWARD SAG 091 ROCKV	GEL FÜNERA VILLE PIKE	L DIRECTI	ON, INC. LE, MD 2	0852
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that ca	used the death. Do not ent	er the mode of dyin	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between
4	Pnysician	e i	Immediate Cause (Final disease or condition	, DEBII						Onset and Death MONTHS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):					
	LAdillilei		Sequentially list conditions,	b. DEMEN						YEARS
	ed isit	Jule	if any, leading to immediate cause. Enter Underlying		or as a consequence of):	201.01				LIDEKO
•	xecut and al-trar	Exami	that initiated events resulting in death) Last	0.	ARDIAL INFARC or as a consequence of):	TION				WEEKS
8760,	cate be executed physician and the burial-transit	dlcaiE		d						
89	uficat g phy as the	edic							1.0	
Вох	death certifi e attending l id for use as	N/	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy	Testania programa			23d. Date of de	livery
	0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of death 5]Ectopic pregnancy] Other <i>(specify)</i>			Month	Day Year
P.0	at the de by the a stached i	hys	9 🗆 Unknown	7					<u> </u>	
	requires that the	by	Part II. Other significant conditions	contributing to de	ath but not resulting in the u	nderlying cause giv	en in Part I.			o the cause of death?
brd	w requir been si should	ted						1 \(\text{Yes}	21∆INo 3 □ P	robably 4 Dunknown
Records,	aw as b	ompleted						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
H		Co						performed 1 ☐ Yes 2 🔀	? death? No 1 ☐ Yes	2 □ No
Vital	sician: certifica rector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death			
of	Phys this al di	2	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date o	npatient 2 EP/Outpatien f Injury 28b. Time o		er: 4 Nursing Hon	ne 5 Residence		city)HOSPICE
on	ding I h. After funer	tion	1 X Natural 5 ☐ Pending	(Monti	h, Day Year) Injury	Wor		od. Dodolibo novi	injury cocurred	
Division	or Attending after death. Diractor: After in by the fune	fica	3 Suicide 6 Could not b	28e. Place	of Injury - At home, farm, str					ural Route Number,
Ö	al or A safter Il Dira	Certification;	4 Homicide	buildin	ig, etc."(Specify)			City or Town, S	tate)	
	ne Hospital or a 124 hours after ne Funeral Dire	edical (29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the minar: On the ba and mann	best of my knowledge, death sis of examination and/or in er stated.	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Mon.	th, Day, Year)
)) / K/		MI	D356	35	JUN	IE 29, 20	04
	D		30. Name and address of person who	completed cause	e of death (Item 23a) (Type,					
			OSEPH KAPLAN M.D.			P DRIVE,	OLNEY, MA	RYLAND 20	832	
	Sta Registr		31. Date filed (Month, Day, Year)		agistrar's Signature	Spark	21			

DHMH 17 Rev 1/2001

SPINACK, LILLIAM

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 13, 2004 July 11:55A. Solomich . /Medical 4a. Facility Name (If not institution, give street and number)

Glade Valley Nursing Home 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Walkersville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 M 2□ F Months Days Hours **8**5 209-05-6834 Director 22,1919 Pennsylvania Usual Residence of Decedent the Maryland 10c. City Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if itam 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examinating number once. 10a State 10h County 10d. Inside City Limits 1 ¥ Yes 2 □ No Frederick Maryland Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6471 Forest Hills Court 21701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ☐ ☐ T T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🙀 No Specify: 2 WW II White 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Fitter Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Solomich Mary Dacko Michael 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas R. Solomich/Son 5710 Aylesboro Ave., Pittsburgh, PA 15217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 → Surial 2 Cremation 3 Removal from State 7/17/2004 Pittsburgh, PA 15217 ' 4 □ Donation 5 □ Other (Specify) Calvary Cemetery 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a, atv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Priysician neumonia . Week disease or condition resulting in death) /Medical consequence of): Due to (or as) Examiner bra Vascular Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes menitur 1 ☐ Yes 2XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pertention relodysplasin C m To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 XNo 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funaral Diractor: A investigation 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check one) 29d. Date signed (Month, Day, Year) 29b. Signature Heren, nho 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thonson 32. Registrer's Signature 31. Date filed (Month. Dav. Year) State JUL 1 4 2004 Registrar

			State of Marylan		artment of H				
			Registrer 1. Decedent's Name (First, Middle, Last)		inouto or i		2. Date of Death	Day Yes	3. Time of Death
	Physici /Medic		Mary Delia Tay	man				8, 2004	2:50 A M
ķ	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of D	eath
			St. Mary's Nursing Center	la a é la india ala ì		Leonardtow			int Marys
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1 ☐ M 2 ☐ F	89 Yrs.	Months Days	Hours Min.	(Month, Day, Y		Birthplace (State or Foreign Country)
Ь.			Usual Residence of Decedent				August 30	, 1914	Maryland
	yland		10a. State 10b. County 10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Main signature	ctor	Maryland Saint Marys		Le	xington Pa	rk		1 ☐ Yes 2 ☑ No
	ith th	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What	Country?
	ath w		21895 Pegg Road, Apt. 234			20653			USA
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Hace - A Black, W	merican Indian, hite, etc.
50	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		I∐Yes 2∭∏No	Specify:		Specify: W	nite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal hygiene. id other than "neturel", or terms 23a or 28a-f show event, if a Medical Ever if et hust be notified at		15. Decedent's Education		lent's Usual Occupa		. 16	Sb. Kind of Busine	ss/Industry
25	hin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. i	kind of work done of OO NOT use retired,	furing most of worl)	ang		
7	filed wit Hygiene ther the	Son	7		Home	maker		70	vn Home
2	be file tal Hy d oth	e	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma	uiden Sumame)	
<u>\</u>	2 should be and Mental Is marked o	٦°	William Samuel Harding					ane Tippett	
<u>a</u>	12 sh and r Is m		19a. Informant's Name/Relationship (Type, Print)				ral Route Number, (
	1 and Health 8m 27 ther to		Joseph Leo Harding / Nephew 20a. Method of Disposition 20b. F		525 Mechanic sition (Name of			sville, Ma	or Town State
၌	Pages 1 and 2 should be nent of Health and Ments int: If item 27 Is marked iry or other treumatic e		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery, crer	natory or other place	θ) T 1	10 2004		
altimore,	permit. Page Department of Importent: If any injury or once.	1	. 4 ☐ Donation 5 ☐ Other (Specify) Qu 21. Signature of Funeral Service Licensee	22	Peace Cemete . Name and Addres	s of Facility	F		lle, Maryland
ñ	Dep Imp	i en	I Simon	Ma P. (attingley-Ga). Box 270.	ardiner Fur Leonardtov	neral Home, n, Maryland	P.A.	
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	Pnysician		Immediate Cause (Final disease or condition	61	1				Onset and Death
	/Medical		resulting in death) a Due to (or as a conseq			,			60 mo.
	Examiner		Sequentially list conditions, b.						
	be iis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uance ol).					
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9/8	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai E							
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ŏ	leath certific attending p	In/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Feta		Ectopic pregnancy			23d. Date of	
n.	death he ath ed for	Physician/Me	1 Yes 2 No		Other (specify)			Month	Day Year
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S,	signer bed	by	Part II. Other significant conditions contributing to death but not res	ulting in the ul	ideriying cause give	en in Part I.	1 ☐ Yes		Probably 4 Dunknown
0	w require been sij should b	etec	Sower Street	ia	1		-		
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Vital	n: Th ficate ir. pag		25. Was associated to medical				1 ☐ Yes 2 2	ZNo 1□Y	es 2 No
	s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Othe		th (Check only one) ome 5 \(\subseteq \text{Residence}	e 6 MOther /S	necify)
O	g Phy er this	\vdash	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injury Work		28d. Describe how		secury
Ö	Attendin death. ctor: Aft y the fur	atio	2 Accident investigation	Injury		res 2□No			
Division of	l or Atto after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Stree City or Town,	et and Number or State)	Rural Route Number,
	urs af ure af rel D								
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier Check only one) 2 Medicel Exeminer: On the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the time restigation, in my op	ie, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier		29c. License	number	290	. Date signed (Mo	ngh, Day, Year)
)	H S H Ö		I I am I de salte	w	1 1910	o Kor		7/91	04
	000		30. Name and address of person who completed cause of death (Iten	1 23a) (Type,	Print)	2 50 6		111	y
_			Leon W. Berube, M.D., 28170 Old Villag	e Road,	Mechanicsvi	lle, Maryl	and 20659		
	Sta Registi		31. Date filed (Month Cay, Year) 2 2004 32. egistrar's Signa	tue	mark!				
10	negisti	ell		478					

To the Hospital or Attanding I within 24 hours after death.
To the Funaral Director: After

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 04, 2004 O.C.M.E. Freenberg MD Jashal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

-OHEENDE 31. Date filed (Month, Day, Year) 08 2004 JUL

M.D Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			For State Registrar	State of M	Maryland / De <i>C</i>	partment of learning of the contract of the co		d Mental H	ygiene Reg. No?	11.	22600
	Physici /Medic		1. Decedent's Name (First, Middle, Las Kathryn Watts	Tennant				2. Date of D Month July	7, Day 200)4 ^{Year}	3. Time of Death 7:15 a.m
	Examin		4a. Facility Name (If not institution, give 8507 Glenville R	oad			a Park		Mont	y of Death	
	Funeral Director			7. / M 2 x F	Age (In yrs. last birthda 83 Yrs.	y) If Under 1 Year Months Days		Min. Nov • 1	irth 2ay, Yaar 5, 1920	9. Birtho Cour Okla	place (State or Foreign htry) homa
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State Maryland Montgo	mery	10c. City, Town or	Location na Park				1	0d. Inside City Limits 1 ☐ Yes 2√ No
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 8507 Glenville R	oad		10f. Zip Code 20912	2		10g. Citizen of USA	What Cour	itry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itams 23e or 28e-f show any injury go other traumatic event, it is Medical Exercitive to tall be millined at once.	by Funeral	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? 3 {No	3. Was Decedent of If Yes, specify Cut	an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	Bla	ce - Americ ck, White, y: Whi t	etc.
21215-0036	within 72 hor ene. than "naturi	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Gi life	cedent's Usual Occu ve kind of work done . DO NOT use retire yroll Sup	during most of d)		Governme	ent	,
	rid be filed lental Hygid ked othar itc evant , the	To Be Co	17. Father's Name (First, Middle, Last) Isaac Watts			yrorr sup	18. Mother's	Name (First, Middle Robbins	Printin e, Maiden Sumai		ice
Maryland	ind 2 shou alth and N 27 Is mar		19a. Informant's Name/Relationship (7 Harry Leonard Ter			iling Address (Stree					·
altimore,	Pages 1 a ment of Hea ant: If item ury of othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. Place of Dis	position (Name of rematory or other pla Lincoln emetery		July 10, 2004	20c. Location	- City or To	
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licen	J-Cole		22. Name and Addr Francis J 500 Unive	. Collíi rsity B	lvd. W.,	Silver :	Inc. Sprin	g, MD 20901
	Physician /Medical Examiner		23a. Part1. Enter the disease, or condishook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	as a consequence of):	enter the mode of dy	ng, such as car	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, and a minimum all cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):						7
O. Box 6	The law requires that the death certifical the has been signed by the attending phoage 2 should be detached for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 mmths? 1 □ Yes 2 1 No 9 □ Unknown		2 Fetal death at time of death	B Ectopic pregnand Other (specify)	у			ite of delive	ory Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying cause g	ven in Part I.		tobacco use con		ne cause of death?
Records,	The law requir ate has been si page 2 should l	Completed						24a. Wa auto peri 1 Yes	opsy ormed2	Were autoprior to condeath?	psy findings available inpletion of cause of
Vita	yslcian: The is certificate director, pag	Be (25. Was case referred to medical examiner?	I la itali				Death (Check only			
of	ding Phys n. After this funeral dii	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir	njury 28b. Time Day Year) 28b. Time Injur	of 28c, Inju		ng Home 5 Res 28d. Describe	how injury occur)
Division	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	286. Place of	Injury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location City or To	(Street and Numb own, State)	per or Rura	Route Number,
	To the Hospital or A within 24 hours after To the Funaral Direct Completely filled in by	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the be liner: On the basis and manner	st of my knowledge, de of examination and/or stated.	ath occurred at the t investigation, in my	me, date and popinion, death o	lace, and due to the occurred at the time	cause(s) and ma , date and place,	anner as stand due to	ated. the cause(s)
}	IO Some Some	Σ	29b. Signature and title of certifier		m	29c. Licen	se number	1	29d. Date signe	d (Month, I	Jay, Year)
	10		30. Name and address of erson who Brian L. Glenn,	ompleted cause of 125	f death (Item 23a) (Typ 20 Prosper	e.Print) ity Drive	, Silve	r Spring,	MD 2090	04	
	Sta Registi	_	31. Date filed (Month, Day, Year) JUL 0 9 20		strar's Signature	Sparks					

Phys /Me Exar

Funer Direct

		1- State of Maryland / Departi	icate of Death		a.2004 2	23690
icia	n	1. Decedent's Name (First, Middle, Last) Miriam McOuay Tyler	-	2. Date of Death Month July	Day Year	3. Time of Death 2:40 PM
dica nine		4a. Facility Name (If not institution, give street and number) 4b	. City, Town, or Location of Dea		4c. County of Death	
		Genesis ElderCare - The Pines 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11	Easton Under 1 Year I If Under 24 Hr	S 9 Data of Birth	Talbot	
al or		217-09-2944 1 M 2 M F 99 Yrs. M	onths Days Hours Mir		Pag 0 4 Bozma	ce (State or Foreign on , MD .
	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on		100	d. Inside City Limits
	cto	MD Talbot Easton				Y☐Yes 2☐No
Č	ai Dire	10e. Street and Number 1 610 Dutchmans Lane	Of. Zip Code 21601	10	Og. Citizen of What Countr US.A	y?
L	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2√2 No	Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Pue Yes 2 XNo Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - America Black, White, et Specify:White	c.
	npieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	s Usual Occupation of work done during most of we NOT use retired)	orking	6b. Kind of Business/Indu	estry
		11 years Recep	rionist	me (First, Middle, M	Funeral Ho	me
6	10 De	William T. McQuay	Addie	Keithley	Y	
		Martha R. Jump (niece) P.O. B	ddress (Street and Number or F	ritt, Md.	21652	
		20a. Method of Disposition Disposition Burial 2 Cremation 3 Removal from State A Donation 5 Other (Specify)			eavitt, MD	
- BOUCE			me and Address of Facility Carroll Hurl			
		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	Box 518, Se mode of dying, such as cardia	1	1	nterval Between
n al		Immediate Cause (Final disease or condition resulting in death)	- condia YA	Scular	disease	Onset and Death
r		Due to (or as a consequence of):				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
1	edical Ex	resulting in death) Last Due to (or as a consequence of): d.				
		IF FEMALE:				
	Physicianin		opic pregnancy ear (specify)		23d. Date of delivery Month D	ay Year
		Part II. Other significant conditions contributing to death but not resulting in the ander	ying cause given in Part I.	23e. Did toba	acco use contribute to the	cause of death?
Total Internal	ompier			24a. Was an autopsy perform	24b. Were autops prior to comp death?	y findings available oletion of cause of
á	De	25. Was case referred to medical examiner?		ath (Check only one		
F		27. Manner of Death 28a. Date of Injury 28b. Time of	DOA Other: Nursing 28c. Injury at Work?	Home 5 Residen	oce 6 Other (Specify)	
	anoi	2 Accident	Work? 1 ☐ Yes 2 ☐ No			
On whitele and a	Series 1	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	actory, office	28f. Location (Stre City or Town,	eet and Number or Rural F State)	Route Number,
	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigated.	urred at the time, date and plac gation, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as state te and place, and due to th	ed. ne cause(s)
84	2	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Da	iy, Year)
		30. Name and address of per an arm o completed cause of death (Item 23a) (Type, Print ROBLERT STANCHEZ MD 508 1.1.	EWILD AVEN	JUE E	ASTON MI	1 21601
State Stra	м	31. Date filed (Month, Day, Year) 32. Registrar's Signature	e)		,	
1/200	1	11.0				

Registrar

within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physicien and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 6:30 PM April 28,2004 Amanda Joan Tilghman /Medical La. Facility Name (If not institution, give street and number)

Crofton Convalecent Rehab Center Crofton

Crofton Convalecent Rehab Center Crofton

The street and number of the street and number o 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Birthplace (State or Foreign Country)
 WV 5. Social Security Number **Funeral** Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State iral', or Items 23a or 28e-f show Examiner must be notified at 1 Yes 2 No Director MD Prince George Mitchellville 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 11301 Dunde Dr. 20721 US Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 DNo
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Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð 3 Widowed 4 □ Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Madical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 State of NJ Day Care Director 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Elizabeth Carter Samuel Galloway ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11301 Dunde Dr., Mitchellville, Md 20721 Gregory Johnson Nephew 20a. Method of Disposition

1 🖒 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Importent: If * 4 □ Donation 5 □ Other (Specify) <u>Fairview Cemetery May 4,2004 Charles Town, WV</u> 22. Name and Address of Facility 21. Signature of Funeral Service Licenses PO Box 838 any is Jefferson Chapel Charles Town, WV 25414 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Etherosclerotic Heart Disease **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) signed by the aid be detached for ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 211No has page 2 this certificate 1 Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes **2** XNo 2 2 ER/Outpatient 3 DOA ieral Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; Injury 1XXNatural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D2010 July 14,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Rakesh Arora, 14300 Gallant Fox Lane, Suite 222, Bowie, Md 32. Registrar's Signature 31. Date filed (Month_Day, Year) State 1111 2 7 2004 Registrar

		Please T	ype or Print						.egible.	
		1 - For State Registrar	State of Mary		e <i>rtificate of</i>		vientai H	ygiene Reg. Nd. (nnl.	23692
Physic		1. Decedent's Name (First, Middle, Last) Maria E1	isa Salga	do Umar	na		2. Date of D Month July	Day 2,	Year 2004	3. Time of Death 4:08 P. M
/Medi Exami		4a. Facility Name (If not institution, give s		do omai		or Location of Death			County of Deal	
Funeral Director		Shady Grove Advent: 5. Social Security Number 6. Sex		a1 n yrs. last birthda 56 Yrs.		ville If Under 24 Hrs. Hours Min.	8. Date of B	irth Day, Year)	Co	ery hplace (State or Foreign buntry) Salvador
pu »		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Longtion					
death with the Maryland rms 23e or 28a-f show rmust be notified at	ō									10d. Inside City Limits 1 Yes 2 No
r 28a-	Director	Maryland Montgome 1	ГУ	Gaith	ersburg 10f. Zip Code			10g. Citize	en of What Co	untry?
th with		22 Briarstone Lane			2087	77		E1 Sa	alvado:	2
je 2 2	y Funeral	1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give	r in U.S. 13	B. Was Decedent of I If Yes, specify Cub	Specify:			4. Race - Ame Black, White Specify:	
turel,	ed by	3 Widowed 4 Divorced	Year or Dates:	162 Dog		E1 S	Salvado	ran	WI	nite
iled within 72 hours af filed within 72 hours af Hygiene. Sther than "naturel", or ent, the Medical Exami	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Giv	edent's Usual Occu ve kind of work done . DO NOT use retire	during most of work	king		d of Business/	Industry
filed v Hygie		17. Father's Name (First, Middle, Last)		Hous	sewife	18. Mother's Nam	ne (First, Middl		ome lumame)	
2 should be and Mental Is marked o	To Be	Calisto	Salgado				Petron	a Gusi	nan De	e Salgado
permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: If item 27 is marked other any njury or other treumatic event, ones.	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Ma	iling Address (Street	and Number or Ru	ral Route Num	ber, City or	Town, State, 2	Zip Code)
T and lealth om 27 her tr		Lucio Umana/Husban			riarstone		ithersh			
permit. Pages 1 ar Department of Hea mportant: If item 3 any injury or other ones.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	dinoval from State		position (Name of ematory or other pla	1			ation - City or	
it. Pertiment		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		All Soul	s Cemeter 22. Name and Addre	y July	10,200	4 Geri	nantown	ı, Maryland
Ded on Sugar		Muchine	M lu		Û East De					MD. 20877
Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the e cause on each line. Due to (or as a co	Ease	inter the mode of dyi		or respiratory			Approximate Interval Between Onset and Death
Examiner		Sequentially list conditions, b	Due to (or as a co	eles	Mel	したい				5 Jegn
be executed sician and burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a co		s, sian					5 Jego
ifficate t g physic	dlca	d								
death cert e attendin	Physician/Medlc	IF FEMALE: 23b. Was decedent pregnant in the past 12 fronths? 1 \subseteq Yes \subseteq No 9 \subseteq Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐Ectopic pregnanc	у		23	d. Date of deli Month	very Day Year
The law requires that the de tie has been signed by the a tage 2 should be detached	by	Part II. Other significent conditions con	_	ot resulting in the	underlying cause giv	ven in Part I.		tobacco use		the cause of death?
sician: The law requires to certificate has been signerector, page 2 should be	Completed						24a. Was		24b. Were au prior to d death?	topsy findings available ompletion of cause of
	e Co	25. Was case referred to medical					1 Yes	2 No		2 No
ysicia is cert directe	0 8	examiner?	ospital: 1 🗆 Inpatient	2 X ER/Outpati	ent 3 DOA Oth	26. Place of Deat ner: 4 \(\sum \) Nursing Ho			Other (Spec	260
ding Phy th. : After this funeral d	tlon: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time	of 28c. Inju	ry at	28d. Describe			,
or Attending after death. I Director: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S		street, factory, office			(Street and I own, State)	Number or Ru	ral Route Number,
To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier SC Certifying Phys (Check only one)	sicien: To the best of maer: On the basis of exa and manner stated.	y knowledge, dea amination and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the red at the time	cause(s) at , date and p	nd manner as lace, and due	stated. to the cause(s)
To the To the Comple	Me	29b. Signature and title of certifier	1: 0.8		29c. Licens	se number		29d. Date	signed (Month	, Day, Year)
1		May Gar	HIMM		DI	11165		20	13 3	2004
,		30. Name and address of person who con			e, Print)	6.6	cun '	MD	20	VF3
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's		/ / /					
Regist		JUL 0 8 2004	Limer	19	sparks	1				

			State of Maryland / Department of Health and M	0001 00000
	<i>^</i>		1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg. No. U J J J J J J J J J J J J J J J J J J
	Physic /Medi		HELEN Frances VENEY - Nixon	Month Day Year 3:32 β. M
	Examir	ner	4a. Facility Name (If post institution, give street and number) 4b. City, Town, or Location of Death WESTOVER	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign
	Director		221-68-7753 1□M 225 72 Yrs. Months Days Hours Min. Usual Residence of Decedent	10-26-1931 MD
	a-f ehow	ctor	MD 10b. Cougty 10c. City, Town or Location WESTOVER	10d. Inside City Limits 1 Tyes 2 No
	uh with the 23a or 28	Funeral Director	10e. Street and Number 8888 Saw Mill Lanc 10f. Zip Code 31871	10g. Citizen of What Country? U.S. A
21215-0036	ретиіt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow my injury or other traumatic event, the Medical Exercitant could be notified at 2008.	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 3 Never Married 2 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 4 Never Married 4 Never Married 4 Never Married 3 Never Married 4 Never Married 4 Never Married 4 Never Married 4 Never Married 4 Never Married 5 Never Married 5 Never Married 5 Never Married 6 Never Married 6 Never Married 7 Never Married 7 Never Married 8 Never Married 8 Never Married 8 Never Married 8 Never Married 8 Never Married 8 Never Married 9 Never Mar	city Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
15-(iin 72 h n *natu dedica	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of workir life DO NOT use retired) NOT use	
	filed with Hygiene. ther ther	Com	Elementary/secondary (0-12) College (1-40r5+) Teacher Aid	Someist County HEAD START
Maryland	nould be fill 1 Mental H narked oth	To Be	17. Father's Name (First, Middle, Last) EARL Handy ESTher	(First, Middle, Maiden Sumame) ARmwood
Mar	traume		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural MARion E. Bruant - Niece 813 Watkins Way N	The second secon
ore,	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	ate 20c. Location - City or Town, State
Baltimore,	permit. Pages Department of I Important; If its any injury or o		14 Donation 5 Other (Specify) Dalisbury Crematory	-04 Salisbury, MD
Ba	permit Departr Imports any inju		21. Signature of Funeral Service Licensee 2. Name and Address of Facility Thony E. Ward Fu 30639 Hamodon And	neval Homo L Princess Anne, MD 21853
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest, Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Onset and Death
	Examiner		Due to (or as a consequence of): A S C V D	
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
o	cate be executed physicien and the burial-transit	Exar	that indiated events c. c. resulting in death) Last Due to (or as a consequence of):	
8760,		dicai	d	
.O. Box (The law requires that the death certific. Ite has been signed by the attending pl age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
Δ.	res that the de igned by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
rds	v requires been sign should be	ed by		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
I Records,		Completed		24a. Was an autopsy findings available prior to completion of cause of death? 1 \(\subseteq see \) 2/2No \(1 \subseteq see \) 1 \(\subseteq see \) Yes \(2 \subseteq No \)
Vital	sician: certific rector,	o Be (25. Was case referred to medical examiner? 1 X Yes 2 No	(Check only one)
o		H-10	A Nursing Hom	e 5 x Residence 6 □Other (Specify) Bd. Describe how injury occurred
Division	tan leat lor: tor:	icatio	2 Accident investigation M 1 Yes 2 No	
Div	ospital or A hours after unaral Dirac ly filled in by	Certification;	4 ☐ Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are considered and place, are considered and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
	To the To the comp	Ň	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
/			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7/14/04.
			Dr. VIJAY KARUMBUNATHAN 201 HALL H	lightway, CRISFIELD,MD
**E	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
DH	MH 17 Rev 1/20	001		
			ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day TEMPLE В. 2, JULY 2004 8:57A. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery

If Under 1 Year | If Under 24 Hrs.

Days

Birthplece (State or Foreign Country)

29d. Date signed (Month, Day, Year)

7. Age (In yrs. last birthday)

74

Funeral

Physician

/Medical

Examiner

5. Social Security Number

217-26-0723

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1 M 2 ☐ F

Director the Maryland 28a-f ahow 5 Examiner must be Items 23a death 1 Pages 1 and 2 should be filled within 72 hours atter onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Iter the Medical other fraumatic event, 0 permit.

Department of H Important: If Ite any injury or ot

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

Physician /Medical **Examiner**

The law requires that the death certificate be executed burial-transit physicien as the attending use lor should be detached the signed by peen has page 2 certificate Attending Physician: rector. completely filled in by the funeral dir this After 1 death. s after death. within 24 hours a To the Funeral C To the Hospital

8. Date of Birth (Month, Day, Year) May 27, 1930 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Adelphi 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9308 Lynmont Drive 20783 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 汉 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Washington Suburban College (1-4or 5+) Engineer Sanitation Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Veli Temple A. Ruth Gibbons ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avis T. Veli -wife 9308 Lynmont Drive Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Wash. Cemetery 7/6/2004 Adelphi, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatuje of Funeral Service License Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ASYSTOLE disease or condition resulting in death) Minules Due to (or as a consequence of): Myocarchal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner OYYON ary Jelly Due to (or as a consequence of Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 12 No 3 Probably 4 Unknown 1 Tyes 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 🗌 Inpatient 21 ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 🗆 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

Medical

29a. Certifier

29b. Signature and title of certifier

GIM DIA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2004

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32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0 8 2004

DOUNG.

32. Registrar's Signature

THIS DEATH CERTIFICATE IS A REPLACEMENT CERTIFICATE Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leg

ар				State of Ma		epartment of l		•	•	
		-	State Registrar		-	Certificate of		Reg.	1/00	4-2369
	。 /sicia	n	1. Decedent's Name (First, Middle, La Roger Dale Win	mberly				2. Date of Death Month JULY 19.	Day Year 2004	3. Time of Death
	ledić: amine		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death	0011 19,	4c. County of Dea	11:20p [™]
			312 MARSHALL AVEN			LAURE		Pi	RINCE GEO	RGES
Fune Direc				Van alle	(In yrs. last birth	Months Days		8. Date of Birth (Month, Day, Ye JULY 14	ar) 9. Bir C 1951 MAF	thplace (State or Foreign ountry) RYLAND
yland	=		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
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h with th	at De Co	_	10e. Street and Number 12432 FINGERBOARD	ROAD		10f. Zip Code 21770			Citizen of What C	
r deat	7	iner	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S.	13. Was Decedent of I	Hispanic Origin? (Sp		14. Race - Ame Black, Whi	erican Indian,
21215-0036 ad within 72 hours after death with the Maryland glene. et then "naturel", or tlems 23e or 28e-f show	Examin	<u>م</u>	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	ty⊒ves 2 □ N ff Yes, Give Year or Dates:	0	1 ☐ Yes 🍇 💢 No			Specify: WH	
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ire, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "nature!", or Items 23e or 28e-f show	ic event.	a l	17. Father's Name (First, Middle, Las. JOHN K.WIMBERLY)	- POT	LIVEING FINGIL	18. Mother's Nam	e (First, Middle, Maid • WILSON	den Surname)	
, Maryland and 2 should be file salth and Mental Hy n 27 is merked oth	r traumat		19a. Informant's Name/Relationship			Mailing Address (Street 432 FINGER			•	•
			20a. Method of Disposition	Domewal from State	20b. Place of I	Disposition (Name of crematory or other pla	JULY	Date 200	. Location - City or	Town, State
Pages ment of ant: If it	ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☑ Other (Speci		1	VET CEMETE	RY 2004	FRE	DERICK,	MARYLAND
Baltimore, permit. Pages 1 a Department of Hea Important: If item	any in		21. Signature of Funeral Service Lice	nsee		22. Name and Address E.RIDGE	ess of Facility STA VILLE BLVI	AUFFER FUN D. MT. AIF	ERAL HOM Y, MARYL	ES, P.A. AND 21771
- Fnysici /Medi			23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	е.	MULTIPLE	ing, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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8760, sate be ex		dical		d						-
o.O. Box 687 In the death certificate by the attending physic	led for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of the control	2 Fetal death	3 ☐Ectopic pregnand 5 ☐ Other (specify) _	y		23d. Date of de Month	livery Day Year
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OID O	funer	lon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) Inj			28d. Describe how in RECIPITAT		
Oivisi or Atten after deal	in by the	ertification;	2 Accident investigation 3 Suicide 6 Could not lead to determine determined	28e. Place of Inju building, etc	ry - At home, farm . (Specify)	n, street, factory, office	X -	28f Location (Street	and Number or Ruate) 312 MAI	ural Route Number,
oita urs eral	<u> </u>	edical C	29a. Certifier 1 ☐ Certifying P (Check only one)	hysicien: To the best of miner: On the basis of and manner sta	examination and/	death occurred at the ti	ime, date and place,	and due to the cause	(s) and manner as	s stated.
To the Hose within 24 ho	отрі€	Mec	29b. Signature and title of certifier	and mainler Sta	.cu.	29c. Licen	se number	29d.	Date signed (Mont	h, Day, Year)
- ≥ - :	0		I him his	mid		OC	CME	SE	PTEMBER 3	13, 2004
			30. Name and address of person who	completed cause of de	eath (Item 23a) (T		on Ctart	Dalti-		land 21201
18.	Stat				r's Signature	111 P6	an Street	, Baltimo	re, Mary	land 21201
Reg	gistra		31. Date filed (Month Day, Year)	14 Maria	r's Signature	Soul				

			1 - For State Registrar			d / Dep		lealth ar	nd Mental Hy	/giene	gible.	00007
			Hegistrar Decedent's Name (First, Middle,	(ast)	- :		rimeate of	Dealit	2. Date of D	Reg. No.	44	3. Time of Death
	Physici /Medic	al	CHAR	LES EI	LSWOR	TH	WRIGHT	JR	Month July	Day 12,		3:30 A M
	Examin	er	4a. Facility Name (If not institution,			- 9	4b. City, Town, o		Death		unty of Death	
H	F		Frederick Men		lospita 7. Age <i>(In yr</i> s. i		Frede If Under 1 Year		Hrs. 8 Date of B		ederi	
	Funeral Director		178-32-0679	1 □ M 2 □ F	62	Yrs.	Months Days		Min. (Month, D	ay, Year)	Co.	nplace (State or Foreign untry) Insylvania
			Usual Residence of Decedent		02				APLII	23, 199	14 1611	nsylvania
	nylan thow		10a. State 10b. County	. £ _ 1_		y, Town or Lo						10d. Inside City Limits
	e Ma Ra-f s	cto	Maryland Freder	ick	FI	rederi	CK					1⊠Yes 2□No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 1847 Millstream	Drive			10f. Zip Code 21702	2		10g. Citizen		untry?
	deat	ner	11. Marital Status	12. Was Dece Armed For	dent Ever in U.	S. 13.	Was Decedent of H	Hispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. F	Race · Amer	
o	after or Ite	교	1 ☐ Never Married 2 🔀 Marrie		^{2□No} 1961		1 ☐ Yes 2 □ No		Puerto Hican, etc.)		Black, White	
2-003	ral',	d by	3 Widowed 4 Divorced	Year or Da	ites: 1965		10 163 21 X 140	эрөспу.		Spe	ecify:	white
ក់	72 h "natu	Completed	15. Decedent' (Specify only highest	s Education grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done OO NOT use retire	oation during most of	f working	16b. Kind of	f Business/Ir	ndustry
V	within ne. han	μ	Elementary/Secondary (0-12)	College (1	·4or 5+)			,		_	_	
Z	lled y lygie ther t		17. Father's Name (First, Middle, L	2		Poli	ce Office	1	Name (First, Middle	Law en		ment
200	hal had had had had old	Be	Charles E. Wrig								iame)	
Š	d Me d Me nark natio	2	19a. Informant's Name/Relationsh			105 14-10	- Address (Chart	<u> </u>	garet A.			
<u> </u>	d 2 s th an 7 Is I		Mary Ann Wright						or Rural Route Numb			
บั	1 and Healt em 2 ther		20a. Method of Disposition		20b. P				e, Freder:	1CK, Ma 20c. Locatio		
2	ages if it		1 ☑ Burial 2 ☐ Cremation				osition (Name of matory or other place				•	
Dallillio	it. Partmen		* 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service/L		Par		Cemetery		15/2004			
0	Deperment of the perment of the permet of t		21. Signature of Furieral Services.	icensee	17		2. Name and Addre		Stauffer	r Funer	al Hor	mes, P. A.
		-	23a. Part1. Enter the disease, or o	mules (alle						, Mar	yland 2170
	= -		shock, or heart failure. List of	inly one cause on ea	ach line.	1 11	1	-		arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Q	netas		- live	C 6	ncer			145
	Examiner		,,		or as a consequ		·				1	V.
		<u>L</u>	Sequentially list conditions,	b. Director	or as a conseq	y ar	en di	scase			73	CYCS
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			, ,	1					31-
	xecu and	xar	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of);						Jakys
	be e sician buria	icai E			nal	fail	ure					3 deus
000	ficate phys s the			d								- 449
. DOX .	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Fetal ant at time of de	death 3[Ectopic pregnancy Other (specify)	/			Date of deliv Month	very Day Year
Ų.	es that t gned by be deta	by Ph	Part II. Other significant condition	A A		ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
, and a	equir sen s ould	Completed	DIXPERT	1112111	U S				10	Yes 2 ☐ No	3 Prot	bably 4 Unknown
วั	law r as be 2 sh	ple	Anemia						24a. Was		o. Were auto	opsy findings available ompletion of cause of
_	The ate h page	POL	Throm boch	topen	G				perfe 1 ☐ Yes	ormed? 2 No	death?	2□No
<u>a</u>	srtific ctor,	Be (25. Was case referred to medical examiner?	00				26. Place of	Death Check onl	-		
5	hysic his ce I dire	P	1 ☐ Yes 2 No	Hospital: 1 Nr	npatient 2 1	ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursir	ng Home 5 🗌 Resi	idence 6 🗆 C	Other (Specia	fy)
=	ng Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of (Monti	of Injury h, Day Year)	28b. Time of Injury	f 28c, injur Wor	y at k?	28d. Describe	how injury occ	urred	
2	endil sath. or: A he fu	atic	2 Accident investiga	ation			M 1 🗀	Yes 2 □ No				
<u>*</u>	r Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 289. Place	of Injury - At ho	me, farm, str	eet, factory, office			Street and Nur wn, State)	mber or Rura	al Route Number,
ב	Ital o				TP .				1			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier (Check only one) 2 Medical E	Physician: To the xaminar: On the ba and mann	sis of examinat	wledge, deatl ion and/or in	n occurred at the time vestigation, in my o	ne, date and p pinion, death o	place, and due to the occurred at the time,	cause(s) and a date and place	manner as s e, and due to	tated. o the cause(s)
	To t Withi To tl	Ž	29b. Signature and title of certifier	1			29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)
			1 amo!	amo	ma		0	36421		JUL	12,	2004
	10		30. Name and address of person w	no completed cause	of death (Item	23a) (Type,	Print)	1/0	+1.01 -	1 - 1.	Α .	N 0 == 1
	17		James Amt	erena 1	no 9	093	Kidgetie	eld Dr.	#luy Fre	der. c	K, M	121701
	Sta Registr		31. Date filod (Month, Day, Year)	32. Re	egistrar's Signat	ure	5 So	als				
			JUL 4	L A LUUT '	1	/						

			1- For State of Maryland / Department / Department / Department / Department / Department / Depa	artment of Health and M rtificate of Death		ene	23698
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medio		Charles Bertman Woodburn, Sr.		July	Day Year 4 2004	3:00P M
	Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	,	4c. County of Death	
		1	St. Mary's Nursing Center	Leonardtown		St. Mary	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Birth	plece (State or Foreign intry)
	Director		216-38-5007 68 Yrs. Usual Residence of Decedent		Nov. 25	,1935 Mar	yland
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mar-	ctor	MD St. Mary's Hollyw	ood			1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Sireet and Number	10f. Zip Code	109	g. Citizen of What Cou	niry?
	23e	ral	44882 Blackistone Circle	20636		United Sta	tes
	ar deg	Funeral	11. Marilal Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	s afte	by F	1 ☐ Never Married	1 ☐ Yes 27 No Specify:		Specify: Whi	te
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-1 show disal Examiner must be crafffed at	edk	1930	dent's Usual Occupation	16	3b. Kind of Business/Ir	
15	n "na	Completed	(Specify only highest grade completed) (Give	kind of work done during most of works DO NOT use retired)	ing	DE. KING OF BUSINESSYN	ioustry
212	filed within Hygiene. Ither than "	mo	Elementary/Secondary (0-12) College (1-4or 5+) 12th — M	anager		Grocery St	ore
	be file Ital Hyg od othe	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>la</u>	should b nd Ments marked umatic e	To	Richard Martin Woodburn	Beatri	lce Norri	S	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23e or 28a-f show any injury or other traumatic event, the Madical Expedited in unat be notified at once.			ng Address (Street and Number or Rura			,
	and lealth m 27			2 Blackistone Circ			
Baltimore,	Pages 1 nent of H int: If Iter iry or oth			sition (Name of natory or other place) $\operatorname{Ju}[1y\ 7]$		c. Location - City or T	own, State
Ë	then then tant: yury			d-Echols Crematory		harlotte H	
Bal	permit. Departr Importa any inji			2. Name and Address of Facility Br			
	20240			2955 Hollywood Rd	Leonard	town, Mary	
g	2. 180		23a. Part 1. Enter the disease, or complications had caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode or dying, such as cardiac t	or respiratory arres		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)				
В	Examiner		Due to (or as a consequence of): 'ENCEHALO Sequentially list conditions	DATHY			2 weeks
	· · · · · · · · · · · · · · · · · · ·	er	erscholatery and distributions				3 weeks
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ALZEIMER'S	Dist	EDIE	3 georg
ó	exec an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed tile has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical	d				
39	death certifica attending ph d for use as th	Wed	IF FEMALE:	-			
Вох	ath ce ttendi	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of delive	,
0	the a	sici	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		Month	Day Year
<u>a</u> .	that the de led by the a detached f		Part II. Other significant conditions contributing to death but not resulting in the un	adertying cause given in Part I	23a Did toba	cco use contribute to the	as agues of death?
ds,	signed d be det	d by	4 y pothexpo. of sm	idenying cause given in Fait i.		2 ⊠No 3 ☐ Prot	
Ö	w requir been si should	Completed	coronary artem Orsease.		:		
Records,	he law s has ge 2 s	mp	Lairia John Dementia Pous C	ral inthe	24a. Was an autopsy performe	24b. Were auto prior to co	psy findings available mpletion of cause of
a	ilcian: The l certificate ha rector, page	မ ငိ	25. Was case referred to medical		1 ☐ Yes 2 €	No 1 ☐ Yes	2 № No
Division of Vital		8	examiner? 1 ☐ Yes 2 ØNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death		4 Floring 16	
o	Phys er this eral di	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		y)
<u>o</u>	utending Ph death. ctor: After th y the funeral	atio	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 □ Yes 2 □ No			
Vis	or Attendater deatl	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street	et and Number or Rura	l Route Number,
	To the Hospital or Al within 24 hours after or to the Funeral Directompletely filled in by	Certification:	building, etc. (Specify)		City or Town, S	state)	
	Hospital 24 hours 2 Funeral I	edical	29a. Certifier (Check only cone) 2 Medical Examiner: On the basis of examination and/or incone)	occurred at the time, date and place, a	and due to the caus	se(s) and manner as s	ated.
	To the Hospital within 24 hours a To the Funeral completely filled	fedi	and manner stated.				
	or with	Σ	29b. Signature and title of certifier	29c. License number D 51738	29d	Date signed (Month,	
	6					7.7.20	
	6 8		30. Name and address of person who completed cause of death (Item 23a) (Type, KAE T. AUNG, MD., 24435 ME	Print) RUELL DEAN A	D., HOL	LY WOOD !	MD 20636
	Sta	te.	1 1/2	54-18-	/	-/	
羡	Registr	_	31. Date filed (Month July, 1998) 2004 37 Registrar's Signature				

Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10b. City, Town or Location 10c. Street and Number 10c. Street and Number 10c. City, Town or Location	2:00 A. Mary's 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No
Mary Margaret Wood July 2, 2004	2:00 A.M County of Death St. Mary's 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No Notizen of What Country? 14. Race - American Indian, Black, White, etc.
4a. Facility Name (If not institution, give street and number) 38707 Alice Way 5. Social Security Number 213-42-8164 Usual Residence of Decedent 4b. City, Town, or Location of Death Clements Clements 6. Sex 7. Age (In yrs. last birthday) 60 Yrs. 60 Yrs. 4b. City, Town, or Location of Death Clements S. Date of Birth (Month, Day, Year) January 13, 1	944 St. Mary's 944 Party Indian, State of Poreign (State or Foreign Country) 944 Party I and 10d. Inside City Limits 1 Yes 2 No 14. Race - American Indian, Black, White, etc.
Funeral Director 5. Social Security Number 6. Sex 1 M 2 F 60 Yrs. If Under 1 Year If Under 24 Hrs. Amonths Days Hours Min. Amount Days Hours Min. January 13, 1 Usual Residence of Decedent	9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No Itizen of What Country? 14. Race - American Indian, Black, White, etc.
Funeral Director 5. Social Security Number 21.3 - 42 - 8164 Usual Residence of Decedent 6. Sex 1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No tizen of What Country? 14. Race - American Indian, Black, White, etc.
Usual Residence of Decedent	10d. Inside City Limits 1 ☐ Yes 2 ☑ No tizen of What Country? 14. Race - American Indian, Black, White, etc.
	1 Tes 2 No
Maryland St. Mary's Clements Maryland St. Mary's Clements 10f. Zip Code 10g. Circle 10g. Ci	1 Tyes 2 No Notizen of What Country? 14. Race - American Indian, Black, White, etc.
Party fattid St. Plary's Crements 10e. Street and Number 10f. Zip Code 10g. Ci	tizen of What Country? 14. Race - American Indian, Black, White, etc.
38707 Alice Way 38707 Alice Way 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Married 1 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 2 Married 1 Married 2 Married 1 Married 2 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 2 Married 1 Married 2 Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married 2 Married 2 Married 1 Married 2 Married 2 Married 2 Married 1 Married 2	14. Race - American Indian, Black, White, etc.
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11 Never Married 2 Married 11 Never Married 2 Married 12 Named Forces? 1 Never Married 2 Married 11 Never Married 2 Married 12 Named Forces? 1 Never Married 2 Married 11 Never Married 2 Married 12 Named Forces? 1 Never Married 2 Married 11 Never Married 2 Married 12 Named Forces? 12 Named Forces? 13 Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Yes 2 Who Specify: 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)	14. Race - American Indian, Black, White, etc.
Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
3 ₩ Widowed 4 □ Divorced If Yes, Give X Year or Dates: 1 □ Yes 2 ₩ No Specify: 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) 16b. K	Specify: White
15. Decedent's Education (Specify only highest grade completed) (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)	
(Specify only riignest grade completed) [Give kind of work done during most of working life. DO NOT use retired) [Give kind of work done during most of working life. DO NOT use retired)	ind of Business/Industry
N % 12 Homemaker Own	Home
The second secon	Sumame)
The state of the s	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of	or Town, State, Zip Code)
Joseph Kenneth Wood/Son P. O. Box 801, Hollywood, MD 20636	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Lo	ocation - City or Town, State
St. John's Cemetery July 7, 2004 Holl	ywood, Maryland
20a. Method of Disposition 1	
P.O. Box 270 Leonardtown, MD 20650	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition Immediate Cause (Final disease or condition resulting in death) Lung Cancer The to (or an accompany and the condition of	31135t all 0 304(t)
Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
Eause (Disease or injury	
if any, leading to immediate cause. Enter Underlying Cause (Olisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
Cause (Oisease or injury that initiated events resulting in death) Last Could be produced by the country of th	
as the state of th	
D IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)	23d. Date of delivery
in the past 12 months? 1	Month Day Year
So the state of th	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use Section 25.	use contribute to the cause of death?
1 X Yes 21	□ No 3 □ Probably 4 □Unknown
1 — Yes 2 24a. Was an autopsy performed? 1 — Yes 2 XI No	24b. Were autopsy findings available
autopsy performed?	prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner?	13.103 25.10
24a. Was an autopsy? Comparison of Death Check only one	6 ☐Other (Specify)
27. Manner of Death 1 XNatural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28d. Describe how inj	y occurred
The state of the	
27. Manner of Death 1 XXNatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Location (Street an City or Town, State)	d Number or Rural Route Number,)
The state of the s	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one)	and manner as stated. place, and due to the cause(s)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date	e signed (Month, Day, Year)
29. Sylvatore and the of certains 1	17 168
Ac .	17104
30. Name and ad s of person who completed cause of death (Item 23a) (Type. Print) Dr. Jengafer M. Schmidt, D.O., 2050 Wildewood Center, California, MD 20619	
State 31. Date filed (Month, Day, Year) 32. Segistrar's Signature	

				State of M	aryland	•	irtment <i>tificate</i>			Mental Hy	rgiene Reg. No. 🕦	01	00701	
	7		1. Decedent's Name (First, Middle, Las	it)	·					2. Date of De	eath (Year	-3. Time of Deat	H
	Physicia /Medic		DEEDRA J	OYCE WI	RIGHT	1				JÜLY	6, Day 20	04	0927	
>	Examin		4a Facility Name (If not institution, give						_	Location of Deat	n 4c. Cour	nty of Deeth	Manna	
			12626 Black S			and the last of the last	If Under 1	Į.	German 1 Under 24 Hrs			ONTGO		•
	Funeral Director		5. Social Security Number 6. S 214-60-2100	9X	ge (in yrs. ia 53	st birthday) Yrs.			Hours Min.	(Month, Da	^{ay, Yeer)} 14,19	5 7 TA	place <i>(State or Fore</i> ntry) 7 . Virgin	∍ign vi∋
		ŀ	Usual Residence of Decedent		J J					Judile	14, IJ.)	·VILGIII	ща
	how		10a. State 10b. County		10c. City	Town or Lo						1	10d. Inside City Lim	
	r 28a-f show	cto		omery		Ge	rmant						1 🛛 Yes 2 🗆 I	No
	Vith th	ă	10e. Street end Number	- 221 - T.			10f. Zip C		20874		10g. Citizen o	of What Coul	-	
	s 23	erai	12626 Black S	12. Was Decedent		i. 13. V	Vas Deceder			specify Yes or No		ace - Americ		
020	within 72 hours after death with the Marylend ene. than "netural", or itams 23e or 28e-f show he Madical Exam or must be motified at	by Funeral Director	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2X tf Yes, Give Year or Dates:			Yes, specify		Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	В	Black, White, cify: Whi	etc.	
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gre	ucation		16a. Deced	ent's Usual (Occupation	on ing most of wo	rkina	16b. Kind of	Business/In	dustry	
21	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or	5+)						Dank	of 7	morian	
121		S	12th 17. Father's Name (First, Middle, Last)			-	Bank			me (First, Middle			merica	
and	d be fi	Be	William B.	Stafford	4			"		ie B.	, Waldell Sulli	amej		
7	12 should be f n end Mental h is marked of raumatic eva	은	19a. Informent's Name/Relationship			19b. Mailir	g Address (S	Street and			er, City or Tow	vn, State, Zij	Code 20874	 L
×	i and 2 : Health er em 27 is	Ì	Dale W. Wrigh	t (Husba	and)					e Ln.,				
ore,	nit. Pages 1 end 2 should be filed setment of Health end Mental Hyg ortant: If Item 27 is marked othar injury or other traumetic event,	Ī	20a. Method of Disposition 1€ Burial 2 □ Cremation 3 □	Dama and from Chata	20b. Pla	ace of Dispo metery, cren	sition (Neme netory or other	of er place)		Date	20c. Location	n - City or To	own, State	
<u><u></u></u>	Page ment if		4 □ Donation 5 □ Other (Specify		A11		ls Ce		_	7/10/0			own, MD	
Baltimore, Maryland 21215-0020	permit. Pages 1 end 2 Department of Health of Important: If item 27 is eny injury or other tra		21. Signature of Funeral Service Liber	Thow	dle								ME, P.A ID 20850	
		7	23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	plications that cause	d the death.	Do not ent	er the mode	of dying,	such es cardia	c or respiratory a	ırrest,	1	Approximate Interval Between	
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ta		BeC	25. Was cese referred to medical					2	6. Place of De	ath (Check only	Λ		2103 210/10	
Ξ	ysician: is certific director,	2 B	examiner? 1 XYes 2 No	Hospital:	ent 2 🗆 E	R/Outpatien	t 3 DOA	Other:			idence 6 🗆 C	Other (Specil	y)	
o uo	<u>₹</u>		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	iry Iy Year)	28b. Time of Injury	M 280	. Injury at Work? 1 ☐ Yes	t s 2□No	28d. Describe	how injury occ	urred		
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	• Hospita 124 hours • Funera etely fille	edical	29a. Certifier 1 Certifying Ph (Check only one) Medical Exam	ysiclen: To the best Iner: On the basis o and manner st	f examinati	ledge, death on end/or inv	occurred at estigation, in	the time, my opini	date and place ion, death occu	e, end due to the urred et the time,	cause(s) and a date end place	manner as s e, end due to	tated. the cause(s)	
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			30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)		01	p.1	11/1/2	MD	MODE	7
			31. Date filed (Month, Day, Year)	32 Banisti	ar's Signat	// //,	IOMTO	250	Nay	NOCK	VIIIE	1111	20002	
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П	Physici	an	Decedent's Name (First, Middle,	•						-		2. Date of 0 Month	eath	ay	Year	3. Time of	Death
	/Medi	cal	Ronald R. Wal				<u>-</u>		-			Ju1y	3, 2	2004		6:40	AM
	Examir	er	4a. Facility Name (If not institution,		,	. 1				Location	of Death			c. County			
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	Director		213-23-2003	1 X M 2 □		71	Yrs.	Months	Days	Hours	Min.	8. Date of E (Month, I June 2	6, Yea	933	Jama	place (State o ntry) 11ca	roreign
	pu >		Usual Residence of Decedent			40. 00						1					
	shov	5	10a. State 10b. County				, Town or Lo									10d. Inside Cit	•
	the N	by Funeral Director	Maryland Montg	omery		Sil	ver Sp	ring 10f. Zip	Codo				10- 6			1X Yes	
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စ္	or Ite	Ē	1 ☐ Never Married 2 🏋 Marrie	d 1 🗆 Y	d Forces?	No						ecify Yes or N Rican, etc.)		Blac	k, White,	etc.	
003	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year	s, Give or Dates:			1 🗆 Yes :	ZIXI No	Ѕреспу:				Specify	: B1a	ack	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Uther then "neturel", or items 23e or 28e-1 show ent. It is Mydical Examinar must be notified at	Completed	15. Decedent's (Specify only highest		ted)		16a. Deced	dent's Usua kind of wor DO NOT us	rk done a	luring mos	t of work	ing	16b.	Kind of Bu	siness/In	dustry	
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lar	uld be Jenta rked tic ev	ToB	Justin Walters							Vero	nica	Campb	e11				
Maryland	2 sho and I Is ma		19a. Informant's Name/Relationshi	р (Туре, Print))		19b. Mailin	g Address	(Street a			al Route Num		or Town,	State, Zip	Code)	
3,5	and ealth m 27		Andrew Walters	(son)						k Te		e, Sil	ver	Sprin	ng, M	ID 209	06
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any njury or other treumatic event. The Mudical Examinar must be notified at once.		20a. Method of Disposition 1 ↑ ↑ Burial 2 □ Cremation :	3 ∑ Removal f	rom State	Cei	ace of Dispo metery, cren	natory or o	ther place	·		Date		Location -	•		
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687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d			///\/	-/-/			J						
X	attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes	, outcome	of pregnan								23d. Date	of delive	ırv	
m m	daatl	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□P	ive birth regnant at			Ectopic pre Other (spe						Mon		*	ear
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	Hosp 24 ho Fune Fune	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	caminer: On th	ne basis of	examinatio	ledge, death on and/or inv	occurred a estigation,	it the time in my opi	e, date and nion, deat	d place, a h occurre	and due to the ed at the time,	cause(s date an	and man d place, ar	ner as st nd due to	ated. the cause(s)	
	To the Hospitel or Attending Physicien: which 24 hours after deals after deals. To the Funerel Director After this certification that the funerel director, it is the funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director, it is a funeral director.	Me	29b. Signature and title of certifier	and r	manner sta	teu.			License					ite signed			
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	Sta Registr	-	31. Date filed (Month, Day, Year)		2. Registra		19	Span	No 1								
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
RUTH E. WELDON 2. Date of Death Day **Physician** JULY 4 2004 4:10P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Montgomery Rockville If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√2 F 91 579-09-8878 Director Apr. 12, 1913 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at Maryland Baltimore 1√2 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 308 Charter Oak Avenue 21212 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian , or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. I be more if them 27 is marked other then "neturel", or Itel any injury or other treumatic event 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Johns Hopkins College (1-4or 5+) Elementary/Secondary (0-12) Elevator Operator Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin F. Harrison Bessie J. Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi H. Webb -sister 13105 Flint Rock Drive Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) vational Mem. Park 1707200.

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.

4400 Powder Mill Rd. Beltsville, Mary and 20705

Approximate Interval Between Onset and Death Maryland National Mem. Park 7/8/2004 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician Cerebralvascular Accident /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or deriging Cause (Disease or injury that initiated events resulting in death) Last Hypertension
Ue to (or as a consequence of) Examine the burial-transit that the death certificate be executed and Due to (or as a consequence of): Records, P.O. Box 68760. physician Physician/Medical ed by the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown G.I. Bleeding; Urinary Tract Infection Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 2**∏** No 1 TYes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No HOSPICE Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After or Attending 5 Pending 1 XNatural s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier To D09470 July 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, M.D. 10400 Connecticut Avenue Kensington, Maryland 20895 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 07 2004 Registrar

			For	State of M	laryland					nd N			101	007	0.1
			- State Registrar			Cer	tificate	OT L	Jeath		2. Date of Dea	leg. No.	114	3. Time of 0	Death
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	the M	Ü	10e. Street and Number	- under			10f. Zip C					10g. Citizen	of What Cou	ntry?	
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	ns 23	Funerai	11. Marital Status	12. Was Deceden		S. 13.	Was Decede	nt of His	spanic Orig	gin? (Sp	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
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03	irat',	Completed by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	:										
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0 0	Hygir Hygir Sther		17. Father's Name (First, Middle, La	ist)						r's Nam	e (First, Middle,	Maiden Sui	mame)		
an	should be filed within 72 hours after death with the Maryland of Mental Hygene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a or 28a-f show marked other than "natural periolitied at impalte event, it a Medical Exercitive mante.	To Be	David A. Woodl	ing					Verr	na S	. Kelvir	ngton			
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0	if ite	14 8	20a. Method of Disposition XXBurial 2 ☐ Cremation 3		Hil	lace of Dispo emetery, crei lcrest	matory or oth	Gar	dens	7/	13/2004				
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Ba	permit. Pages 1 and 2 should by Department of Health and Menta Importent: if Item 27 is marked any injury or other traumatic angones.) todd	E, XU	Sk	J 14	7 Duke	e of	Glou	ices	ter St.	Annap)1
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<u>α</u>	that the do ed by the detached		Part II. Other significant condition	! is contributing to death	n but not res	ulting in the	underlying ca	ause giv	en in Part I		23e. Did t	obacco use	gontribute to	the cause of di	eath?
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	ing After une	00	27. Manner of Death Natural 5 Pending		njury Da <i>y Year)</i>	28b. Time of Injury	of 21	8c. Injur Wor	yal k? Yes 2.⊟	No	28d. Describe	now injury o	ccurred		
isio	Attending ir death. ector: After by the fune	icat	2 Accident investigated as Suicide 6 Could no	ot be and Blace of	Injury - At h	ome, farm, s				,,,,,	28f. Location (lumber or Rui	al Route Num	ber,
Division	of or Attendiate after death Director: A	Certification:	4 Homicide determin	building,	etc. (Specia	fy)	,	,			City or To	wn, State)			
	To the Hospitel or / within 24 hours after To the Funerel Dire completely filled in b	Medical C	29a Certifier Check only 2 Medical E	Physician: To the be examiner: On the basis	s of examina	owledge, dea ation and/or i	th occurred anvestigation,	at the tir	me, date a	nd place ath occu	, and due to the rred at the time,	cause(s) an date and pl	nd manner as ace, and due	stated. to the cause(s)
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			30. Name and address of person y	no completed cause of	of death (Ite	m 23a) (7) ge	Print)	*	V	· U	111	11	(0	
			Ainde	/n 3401	19/10/15	Mb 214	Poj Hu	nne	H	ven	del	Ted	(()	(anto	
		late	31. Date filed (Month, Day, Year)	2004 32 Aeg	istrar's Sign	ature	and le								
	Regis	UEU	JUL V O		_	- /45	-								

		-	For State				artment of H		nd Mei			0.1	A A ***	A. Jan.
			 State Registrar AMEND#12, 20a Decedent's Name (First, Middle, L 		,н <u>м</u>	'MOOBAGI	lilicate of t	Jeani		Date of Dea	Reg. No.	ــنال	3. Time of	Death
	Physicia	an	ROBERT	JOSEP:	Н	ZAVA	ATCHAN		2.	Month	Day 3 200	Year 4	3:57	P _M
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of	Death	001		nty of Death		
	LAGITITI	ÇI	NATIONAL NAV	AL MEDICAL	CENT	ER	В	ETHESD	A		М	ONTGO	MERY	
	Funeral			Sex 7. Ag	e (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8.	Date of Birtl (Month, Day	h	9. Birth	place (State o	r Foreign
	Director		208-16-3394	1 ☑ M 2 ☐ F	78	Yrs.	Midital Bayo			ov. 7,	1925		nnsylva	nia
	pur *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside Cit	ty Limits
	Aaryla f aho	5	Maryland Montgo	mery		lver S							1 🗆 Yes	
	28a-	Director	10e. Street and Number				10f. Zip Code				10g. Citizen o	of What Cou	untry?	
	3a or	٥	1918 Alberti Dr	ive			20902	2			USA			
	ms 2	Funeral	11. Marital Status	10 Was Dosedost	Ever in U.	S. 13.	Was Decedent of H	ispanic Origi	in? (Specif	Yes or No-		ace - Amer		
21215-0036	os 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 ia marked othar than "natural", or itams 23a or 28a-1 ahow othar than "natural", or itams 23a or 28a-1 ahow othar traumatic avant, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1	1944- 1960	C 77	If Yes, specify Cuba 1 ☐ Yes 2 2 No		Puerto Ric	an, etc.)		llack, White cify: Whi		
ğ	2 ho	ted	15. Decedent's			16a. Dece	dent's Usual Occupa	ation	of working		16b. Kind of	Business/Ir	ndustry	
215	thin 7 e. an "r	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or!	5+)	life.	DO NOT use retired	1)			_		_	
	ed wi	S		2		Fir	re Safety						Govern	nment
Maryland	uld be fill fental H rked oth tic avan	To Be	17. Father's Name (First, Middle, La Michael Zavato						na Pyc		Maiden Sum	ame)		
ary	and Nand Islama		19a. Informant's Name/Relationship				ng Address (Street							
	and ealth m 27 nar tr		Barbara J. Zava	tchan/ Wife			3 Alberti	Drive						
Baltimore,	ges 1 t of H if ital		20a. Method of Disposition 1 ⊠ Burial 2 ☑ Cremation 3	☑Removal from State	206. P	etropo	sition (Name of 1410 or other place	(e)	-	-7, 8	20c. Locatio			
Ë	tant:		`4 ☐ Donation 5 ☐ Other (Spe	0 0	,		atory	1	200				, Virgi	inia
Ba	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signatur Funeral Service Co	Scenti	7	50 50	Prancis J O Univer	· Coll sity B	ins I	Tunera W., S	l Home ilver	Inc. Sprin	g, MD	20901
	奇		23a. Part I. Enter the disease, or co shock, or heart failure. List or	implications that caused by one cause on each li	d the death	n. Do not ent	er the mode of dyin	g, such as ca	ardiac or re	espiratory ar	rest,		Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	_a SEPS	IS								Onset and I	Эватп
	/Medical Examiner		resulting in death)	Due to (or as		uence of):								
ı	LAdillilei .	_	Sequentially list conditions,	b. MULT Due to (or as			RGAN FAIL	URE						
	ed	nine	Sequentially list conditions, any seeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as	a consequ	derice oil.						- (
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequ	uence of):								
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687	ificate g phy as the	edic				-0.000			10111					
Вох	death certific e attending p d for use as t	Physiclan/Medlcal	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy				23d. I	Date of deliv	very	
	ne death the atte	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (specify)				'	Month	Day Y	'ear
P.0.	t t by	hy	9 Unknown											
	es pe	by	Part II. Dther significant condition	s contributing to death b	out not resu	ulting in the u	nderlying cause give	en in Part I.					the cause of d	
ord	w requires been sign should be	ted							_	1 🗆 Y	es 2X No	3 Pro	bably 4 🔲	nknown
of Vital Records,	aw as b 2 st	Completed								24a. Was autop	sy	prior to co	opsy findings a ompletion of ca	available ause of
	Th ate pag	Cor								1 Tes	med? 2 XNo	death?	2 No	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			ot 3 DOA Oth	0.0		heck only o				
of		1.	1 ☐ Yes 2 📉No 27. Manner of Death	1 X Inpati		28b. Time o	IL SCIDON	4 🗀 Nuis			lence 6 C		ify)	
	ding Ph h. After th funeral	tlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju (Month, Da	y Year)	Injury	Wor	k? Yes 2 □ N			, ,			
Division	or Attanding after death. Diractor: Aftel in by the fune	fica	3 Suicide 6 Could no	the	jury - At ho	ome, farm, st	reet, factory, office		28f			mber or Rur	ral Route Numi	ber,
<u> </u>	o Piro	Certification;	4 Homicide	building, e	tc. (Specif)	y)				City or Tow	m, State)			
	2 5 5	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex	Physicien: To the best	of examina	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and	due to the dat the time, d	cause(s) and date and plac	manner as : e, and due !	stated. to the cause(s))
	To the Hos within 24 h To tha Fun completely	Med	29b. Signature and title of certifier	and manner st	aled.		29c. Licens	e number			29d. Date sign	ned (Month,	, Day, Year)	
	· V			3	mo		0101	235221	(77.4.3		17	100	104	
	16		30. Name and address of person w	e completed cause of	death (Item	1 23a) (Tyne					L MEDI	CAT. C	ENTER	
			JOON S. YUN L	r MC USN	(11011	/ (/)po,	,				0889 - 5		TILLTIM	
rit.	Sta	ite	31 Date filed (Month, Day, Year)	32. Segist	rar's Signa	ture	1							
÷	Registi	ar	JUL U72	004 Sens	A. Parish of	J	Sparks	1						

				•	artment of Health an	d Mental Hy	giene	
			= State Registrar	Се	rtificate of Death		Reg. No.?	2-3-7-0.5
Н	Physicia		Decedent's Name (First, Middle, Last)	Λ	- 1	2. Date of De. Month	Day Year	22:11 M
1	/Medic	al	Walter	Anoi	4b. City, Town, or Location of D	eath O'	23 2004 4c. County of Death	22.11
	Examin	er	4a. Facility Name (If not institution, give street and number,	10.1	Baltimore	oa	NA	
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday	If Under 1 Year If Under 24		th 9. Birthpl	ace (State or Foreign try)
	Director		212-03- 9367 ¹⊠™ ²□F	89 Yrs.	Months Days Hours	Min. (Month, Da Nov. 7		PA
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10	Od. Inside City Limits
	fanyla f shov	ō	MD Baltimore		Baltimore			1 ☐ Yes 2√2 No
	the N 28a-f	rect	10e. Street and Number		10f. Zip Code		10g. Citizen of What Coun	try?
	3a or	Funeral Director	17 Lombard Drive		21222		USA	
	death	nera	11. Marital Status 12. Was Deceden Armed Forces	Ever in U.S. 13	. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		
9	within 72 hours after death with the Maryland ene. than "natural" or Itams 23e or 28e-f show the Marical Examinar ratal be inclined at	Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. 2 ☐		1 ☐ Yes 2 ☑ No Specify:	. ,	Specify: Whi	
21215-0036	hours ural',	d by	3 XWidowed 4 ☐ Divorced Year or Dates:	163 Dec	edent's Usual Occupation		16b. Kind of Business/Ind	
7	in 72 in 72	Completed	(Specify only highest grade completed)	(Giv	e kind of work done during most of DO NOT use retired)	working		,
212	d with giene.	шо	Elementary/Secondary (0-12) College (1-4or	Bod	y&FenderRepai	r	Auto	
þ	e filed al Hygi I other vant, i	Be C	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle	, Maiden Sumame)	
<u>ya</u>	2 should be filed within and Mental Hygiene. Is marked other then aumatic evant, the Ma	D D	Alex Anoweck			ary Tryb		
Maryland	2 sho and n Ism	E 35	19a. Informant's Name/Relationship (Type, Print)		ling Address (Street and Number of			
	1 and Health am 27 other tr	8	Sharon Anoweck / daugh	20b. Place of Disc	Lombard Driv	e Baltim	20c. Location - City or To	
Baltimore,	of of		1 2 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	a	ematory or other place) onForest 7	/28/04	OwingsMill	s MD
量	permit. Pag Department Important: I any injury o		21. Signature-of Funeral Service Licensee	0/	22. Name and Address of Facility	Connells	FuneralHom	eofEssex
ä	permit. Departr Imports any inj		1 K Terry Con	nelly	300 Mace Av			
			23a. Part1. Enter the disease, or completations that cause shock, or heart failure. List only one cause on each	ed the death. Donot e	nter the mode of dying, such as ca	rdiac or respiratory a	irrest,	Approximate Interval Between Onset and Death
	Pnysician	8 7	Immediate Cause (Final disease or condition	ration D	Neumonia			Tolays
	/Medical Examiner		resulting in death) Due to (or a	s a consequence of)				1 2004
и		<u></u>	Sequentially list conditions, if any leading to immediate b. Due to (or a	s a consequence of):				_ INOMIT
	uted 3 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
oʻ	te be executed ysicien and ne burial-transit	Exa		s a consequence of):				
3760,	± ≥ ±	ical	d					
k 68	e as t	Med	IF FEMALE: 23c. If yes, outcom	o of prognancy			23d. Date of delive	
Вох	death certifics e attending pt od for use as t	ian/	23b. Was decedent pregnant 1 Live birth in the past 12 months?	2 Fetal death 3	B Ectopic pregnancy		Month	Day Year
o.	D 0 D	Physician/Med	1 Yes 2 No 9 Unknown					
<u>α</u>	that the	by Pr	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I.	23e. Did	tobacco use contribute to the	
rds	requires een sign nould be	ed b				1	Yes 2 No 3 Prob	ably 4 Kunknown
Records,	en en cu	plet				24a. Was	s an 24b. Were auto	psy findings available mpletion of cause of
Ä	Th ag	Completed				perf 1 ☐ Yes	ormed? death? 2 S No 1 S Yes	2□ No
/ita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othor	Death (Check only		_
of o	Phys this al dii	5	1 Yes 2 No 1 Inpa 27, Manner of Death 28a. Date of Ir		ient 3 DOA 4 Nuis	-	idence 6 Other (Specify how injury occurred	0
O	ding h. After funer	tion	1 Natural 5 ☐ Pending (Month, L	Day Year) Injur				
Division of Vital	Attending r death. ector: After by the fune	ifica	3 Suicide 6 Could not be 28e. Place of	njury - At home, farm, etc. (Specify)	street, factory, office		(Street and Number or Rura	Il Route Number.
ā	s afte s afte al Dir	Certification:	5 Dullang,	atc. (Specify)				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis	of examination and/or	ath occurred at the time, date and investigation, in my opinion, death	place, and due to the occurred at the time	e cause(s) and manner as s , date and place, and due to	tated. the cause(s)
	tha h	Med	one) and manner 29b. Signature and title of certifier	stated.	29c. License number		29d. Date signed (Month,	Day, Year)
	To with	1	Chartal La Branci	MN	8941.8	9	07/23/20	004
	1		30. Name and address of person who completed cause of	death (Item 23a) (Typ	0.100	•	- 1/23/20	
	D		Christopher J.Bane			Baltimo	ore MD	
		ate		strar's Signature				
	Regist		- 0 2004 Paperta	19	books)			
DH	HMH 17 Rev 1/	2001						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 10:05 A.M **Physician** BARNETT **GLENNIS EDWARD** 04 24 /Medical 4a. Facility Name (If not institution, give street and number)
NORTH ARUNDEL HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL CO. GLEN BURNIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct.30 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1100 M 2□F Months Days Hours Min. 64 220-36-5552 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, Count ir than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at Pasadena Anne Arundel Co. Md. 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21122 9 Margaret Ave. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "na eny injury or other traumatic event. It is Minde 2006. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Pleasure Cove Elementary/Secondary (0-12) Painter Marina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maize Barnett Emi1 Cledith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Margaret Ave. Pasadena, Md. 21122 19a. Informant's Name/Relationship (Type, Print) (Wife) Phylis Barnett 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 08/03/2004 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee 3204 Mountain Road, Pasadena, Md. a Approximate
Interval Between
Onset and Death Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest anock, or heart failure. List only one cause on each line. remediate Cause (Final disease or condition resulting in death) Myo cardial infarction ALLUte Pnysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) □Yes 2 🗹 No Records, P.O. 9☐ Unknown 9 Ulnknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 Yes 2 No Division of Vital al or Attending Physicien: T s after death. al Diractor: After this certificat ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Do0 23811 man m person who completed cause of death (Item 23a) (Type, Print) Crain 304 (Ien Burnie M 2106) onathan Forman MO 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

an	1. Decedent's Name	(First, Midd	19b, State 19b, per 10, Last) BLACKWE		r				2. Date of D Month July 2	eath Day	Year	3. Time of D 0139
al er	VINCENT 4a. Facility Name (If					4b. City, Town,	or Location	of Death			unty of Dea	
er			Hospital	,		Baltin	nore				NA	
•	5. Social Security No	umber	6. Sex	7. Age (In y	rs. last birthday) If Under 1 Yea	r If Under	r 24 Hrs.	8. Date of B	irth		rthplace (State or I
	217-98-71 Usual Residence of	67	1 ∑ M 2□F		22 ^{Yrs.}	Months Days	s Hours	Min.	3/29/1	982		MD MD
_	10a. State	10b. County	/	10c.	City, Town or I	ocation						10d. Inside City
Director	MD		NA		BALT	IMORE						
Dire	10e. Street and Nun	nber				10f. Zip Code				10g. Citizen		ountry?
ra		ITH WA	LK AVE				21239			1 44	USA	
Funerai	11. Marital Status		Armed I	ecedent Ever in Forces?	n U.S. 13	. Was Decedent of If Yes, specify Cu	Hispanic Oi Iban, Mexica	rigin? (Sp an, Puerto	ecify Yes or N Rican, etc.)	0- 14.	Black, Whi	
by F	1 X Never Marrie		If Yes, C	s 2 🕅 No Give		1 X Yes 2 □ No	o Specify	<i>/</i> :		Sp	pecify:	RICAN
	2 🗀 AAIGOMAG	-	1	Dates.	16a Doo	edent's Usual Occi	unation			16h Kind	AN of Business	MERICAN
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Completed	Elementary/Secon		College	(1-4or 5+)		BUS BOY	,			pr	ESTAIL	RANT/CATE
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8			LACKWELL	JR.					E J. DA		,	
²	19a. Informant's Na			JK.	19h Mai	ling Address (Stree					own State	Zin Code)
	JENINE J.			1	7204	ling Address (Street	COUNTE	SA. COL	RT APT	1 BAT.7	rt N	1D 21208
	20a. Method of Disp		(FIOTHER)						Date			Town, State
	1 🔀 Burial 2 [Cremation	3 Removal from	m State	cemetery, cr	oosition (Name of ematory or other pi	lace)					
	` 4 □Donation	/		M		CEMETER	about the contract of the cont		/2004		DOWNE,	
	21. Signature of Fu	neral Service	License	///		22. Name and Add		with the control	LIE FUN			
	23 / P s 11. Enter th	uju	1/			638 N.	GILMUN	SIK	TIT DI	ALTIMOF	KE, MI	21217
	Immediate Cause ((Final	t only one carse or	n each line.		nter the mode of dy	ying, such as			arrest,		Approximate Interval Betwe Onset and De
xaminer		nditions,	a. GU Due t b. Due t	n each line.	MOUNCE sequence of):	nter the mode of dy	ying, such as			arrest,		Interval Betwe
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State

31. Date filed (Month, Day, Year) 2 8 2004 Registrar's Signature Registrar

			1 - For State Registrar		ryland / Dep <i>Ce</i>	artment of I rtificate of			ene g. Xe. 0 0 4	23709
	Physici	ian	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Gladys L. Broo			T		July	26, 2004	11:00 A M
	Examir	ner	4a. Facility Name (If not institution, give Genesis Eldercar		Paulon Cth		or Location of Death		4c. County of Death Baltime	
	Funeval		5. Social Security Number 6. Sec		(In yrs. last birthday			8. Date of Birth		
	Funeral Director			114 000	5 Yrs.	Months Days		8. Date of Birth (Month, Day, July 22	1909 Mari	place (State or Foreign Intry) Yland
	<u>p</u>		Usual Residence of Decedent						, , , , , , , , , , , , , , , , , , , ,	,
	arylar show	_	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits
	ith the Marylan or 28a-f show	ecto	Maryland Baltimo	re		Baltimor	2			1 ☐ Yes 2 No
	with t	Funeral Director	10e. Street and Number			10f. Zip Code	01021	10	g. Citizen of What Cou	intry?
	eath	era	8720 Emge Road	12. Was Decedent B	ever in II S 12		21234	acify Vac or No.	U.S.A.	can Indian
10	r Itan	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 N	0	If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, White	, etc.
93	ours a	by	3 ♥ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: W	hite
215-0036	filed within 72 hours after death with the Maryland Hygiene vitier than "natural", or Itams 23a or 28a-f show with it e Maricul Examination at	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occup	pation during most of work	ina 1	6b. Kind of Business/Ir	ndustry
21	Althin han "	n Jdu	Elementary/Secondary (0-12)	College (1-4or 5-	+)		during most of work ad)	9	2 44	
121	lled v lygie ther t	S	6th Grade 17. Father's Name (First, Middle, Last)		Hor	nemaker	18. Mother's Name	- /First Middle M	Own Home	
anc	d be f ontal h	Be c	Frank Linnbau	m				herine	Rau.	
Maryland	2 should be filled with and Mental Hygiene. Is marked other than aumatic avant, II e M	2	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street			City or Town, State, Zi	n Code)
S	od 2 ;		Mrs. Betty Lou Bea						ore, MD 212	·
re,	s 1 ar f Hea itam othe		20a. Method of Disposition		20b. Place of Disponentery, cre			1	0c. Location - City or T	
Ë	Page not: If nrt: If		1 【XBurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Parkwood			/04 B	Baltimore,	Marul and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene Important: If itam 27 Is marked other than "natural", or Itams 23a or 28a-f show amy injury or other traumatic avant. If a Wasted Last. circle in the training an any injury or other traumatic avant. If a Wasted Examinet in the brindlight at Once.		21. Signature VFuper II Service License	96					Funeral Hom	
8	9 9 E 2 8		- Callan			9705 Bel	air Rd., 1	Baltimore	2, MD 21236	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishook, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death)	CERE	the death. Do not ene. BDDV/2 a consequence of):					Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed: ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit.	cal Examiner	Sequentially list conditions, tary, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	·	consequence of):					
9	tificat ng phy as th	led								
.O. Box	that the death certifice led by the attending ph detached for use as ti	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of delive Month	ery Day Year
Records, P.	w requires that been signed I should be det	by	Part II. Other significant conditions con	NS1 200	t not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to t a 2 X No 3 ☐ Prot	he cause of death? pably 4 []Unknown
al Reco		Completed						24a. Was an autopsy perform 1 Yes 2	prior to co	ppsy findings available impletion of cause of
Vital	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	lospital:		Ott	26. Place of Death			
of	ding Phy I. After this funeral o	tlon: To	27. Manner of Peath Natural 5 Pending	1 ☐ Inpatier 28a. Date of Injun (Month, Day	28b. Time o	f 28c. Injui	4 Yoursing Ho	me 5 Residen 28d. Describe how	ce 6	(y)
Division	irac irac n by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the best oner: On the basis of and manner state	examination and/or in	h occurred at the tir vestigation, in my o	me, date and place, opinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner as s e and place, and due to	tated. o the cause(s)
	To t Withi To tl	ž	29b. Signature and title of certifier		A.A.	29c. Licens			d. Date signed (Month.	
	J.		1/1/1/1	Ca	> /4/2	X. 112)	3967		07-26	2004
	N		30 Name and address of person who co			8731 j	BELANA	ram.	BAUTO	M21236
	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 8 2004	2. Registra	r's Signature					,

			For Stata Registrar		State of	Maryland /	•	nt of Health a		ntal Hy			22710
	Physici		1. Decedent's Name	(First, Middle, L	Bost				2	Date of D		2004	3. Time of Death 3:00 AM
	/Medic Examir		4a. Facility Name (II	not institution, g		cal System		Town, or Location			4c. 0	County of Death	
	Funeral Director	2	5. Social Security No.	umber 6.		. Age (In yrs last b	•	r 1 Year If Under Days Hours		Date of Bi (Month, D	rth ay, Year)	9. Birth	place (State or Foreign ntry)
	show	2	Usual Residence of 10a. State	10b. County		10c. City, Tox	wn or Location	`					10d. Inside City Limits 1 Yes 2 □ No
	or 28a-f	Funeral Director	10e. Street and Nun	nber 0	. 17	Apt 4	101. Zi	o Code			10g. Citize	en of What Cou	
	oms 23a	neral	11. Marital Status	14+.K	Ofal 12 Was Deced Armed Ford	lent Ever in U.S.	13. Was Dece	212/7 Ident of Hispanic Ori orfy Cuban, Mexical	igin? (Specif	fy Yes or N	0- 14	1. Race - Ameri Black, White,	
5-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show disal Examt artitual be tridified at	by	1 Never Marri 3 ☐ Widowed	ed 2□ Married 4 □Divorced		No No	1 ☐ Yes			oun, 610.7	1	Specify:	ACK
21215-(en 2 50	Completed		15. Decedent's ify only highest of dary (0-12)	Education grade completed) College (1-		a. Decedent's Usu (Give kind of will life. D NOT to	ork done during mos	st of working		16b. Kind	of Business/In	dustry
	should be filed withir nd Mental Hygiene. marked other than imatic event, the Market	Be Con	17. Father's Name (First, Middle, La	st)			18. Mothe	er's Name (/	First, Middle	, Maiden S	LCTO/ Jumame)	7
Maryland	2 should be and Menti is marked sumatic e	To	19a. Informant's Na	Me/Relationship	(Type, Print)	19	b. Mailing Addres	s (Street and Number	er or Rural R	Pour Numb	Mac per, City or	Town, State, Zi _l	Code)
_	is 1 and 2 of Health a item 27 is other tre	-	Timoff 20a. Method of Disp	Y Nor	wood (E	20b Place	B18An	CNUE	De /	pt.C	20c. Loc	Ab Mo ation - City or To	2/2/8 own, State
Baltimore ,	t. Page rtment o rtent: If		° 4 ☐ Donation	5 Other (Spec		dreen Green	ery, crematory of	enctory	8/2/	04	Bal	to M)
Ba	Depa Impo eny ir		21. Signature of Fu	Va	An Atres	l	Vaug 495	5 yak	s Rd.	Bals	6-M	12/21	ervices
	Physician		23a. Part1. Enter the shock, or hear firmmediate Cause (disease or condition	t failure. List on Final	ly one cause on ea	used the death. Do ch line.	not enter the mo	de of byng, such as	cardiac or r	espiratory a	arrest,		Approximate Interval Between Onset and Death 3 weeks
	/Medical Examiner		resulting in death)		Due to (c	r as a consequence	e of):						S WEEKS
	suted id ansit	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events	ILITA		r as a consequence	e of):						
8760,	cate be executed physician and the burial-transit	Ical Exa	resulting in death) L	ast		r as a consequence	e of):						
Box 68	r certificat nding phy use as th	n/Medi	IF FEMALE: 23b. Was decedent	pregnant		ome of pregnancy		I Liver on the			23	d. Date of delive	ery
o.	res that the death certific igned by the attending p be detached for use as	Physiclan/Med	in the past 12 1 □ Yes 2 ₽ 9 □ Unknown	months?		th 2 Fetal deat nt at time of death vn	h 3 □Ectopic p 5 □ Other (s					Month	Day Year
Δ.	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	by	Part II. Other signifi	cant conditions	contributing to dea	ath but not resulting	in the underlying	cause given in Part I			tobacco use		ne cause of death?
Records,	The law require ate has been sip page 2 should b	Completed								24a. Was auto perfe	psy ormed2	prior to co death?	psy findings available mpletion of cause of
Vital		Be	25. Was case referr		Hospital:			Other	of Death (1 🗆 Yes	2MNo
of	유부	lon; To	1 Yes 2 27. Manner of Death	5 Pending	28a. Date of (Month		Time of Injury	28c. Injury at Work?	280		how injury	Other (Specif	y)
Division	I or Attencater death Director:	Certification;	2 Accident 3 Suicide 4 Homicide	investigat 6 Could not determine	be 28e. Place of	of Injury - At home, f g, etc. <i>(Specify)</i>	farm, street, factor	1 Tes 2 y, office		Location (Street and wn, State)	Number or Rura	Il Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Ce	29a. Certifier (Check only one)	1 Certifying I	Physician: To the taminer: On the base	sis of examination a	ge, death occurred nd/or investigation	at the time, date an	nd place, and oth occurred	due to the	cause(s) as	nd manner as si lace, and due to	tated.
	To the within 7 To the comple	Med	29b. Signature and	title of certifier	MD		29 A 1	c. License number	51513	33	29d. Date	signed (Month,	Day, Year)
	H		30. Name and addre	Stoych	o completed cause	of death (Item 23a)	(Type, Print)	Beltin	000	Ma	217		
	Sta Registi		31. Date filed (Mont		32. Re	gistrar's Signature	B 4	Baltim					

	1	-	State of Maryland	d / Depa		ealth and M	ental Hygi	_	23711
Physiciar /Medica	1	1. Decedent's Name (First, Middle, Last)	Chambe				2. Date of Death Month	Day Year	4 3;30 PM
Examine		ta. Fecility Name (If not institution, give str	eet and number)		4b. City, Town, or BALTIM	Location of Death		4c. County of De	ath
Funeral Director		212-22-2905	7. Age (In yrs. la	V		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JUNE 1 1	Year) 9. Bi	rthplece (State or Foreign country) IRGINIA
Maryland f ehow		Usual Residence of Decedent 10a. State 10b. County MARYLAND N/A	10c. City	Town or Lo	ocation IMORE				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
vith the Ma	Direc	10e. Street and Number		DITE	10f. Zip Code	0.0	10	g. Citizen of What C	country?
be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23s or 28s-f show event, the Madical Examinar must be notified at	by Funeral	3301 WILKENS AV	ENUE: . Was Decedent Ever in U.S Amed Forces? 1 □ Yes 2 ☑No If Yes, Give Year or Dates:	1	212 Was Decedent of H If Yes, specify Cuba 1□ Yes 2☒No	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	U.S.A. 14. Race - Arr Black, Wh Specify: BL	ite, etc.
hin 72 hours 3. 9. "natural Wedical E.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	tion	(Give	dent's Usual Occup kind of work done of DO NOT use retired	turing most of workii	ng 1	6b. Kind of Busines	
d 2 should be filed within 72 hours at the and Montal Hygiens and 18 to 18 marked other then "natural", or traumatic event, the Medical Example To De Company of the Medical Example To De Company of the Medical Example of the Post of the Medical Park of the Medical P	e n	unknown 17. Father's Name (First, Middle, Last)		De	OMESTIC	18. Mother's Name	(First, Middle, M	SELF Maiden Surname)	
should and Men marke umaric	0	unknown 19a. Informant's Name/Relationship (Type	e, Print)	19b. Maili	ng Address (Street		LEE MIL / Route Number,	LER City or Town, State,	Zip Code)
	c d	Monte Chambers/So:	20b. PI	ace of Dispe	3 Columbu osition (Name of matory or other place	D		Maryland 20c. Location - City of	
permit. Pages t a Department of Hea Importent: If Nem any injury or othe once.		1 A Burial 2 ☐ Cremation 3 ☐ Re- 1 Donation 5 ☐ Other (Specify) 21. Signature of Faheral Service Coenses	AR	2	MEMORIAL 2. Name and Addres TITIAM C	07-2		BALTIMORE,	
		Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final	ations that caused the death		1206 W INO	KTH AVENU	t r respir uory arre	ist,	Approximate Interval Between Onset and Death
	cal Exa	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of the consequence of t	mer iene of):	104				
res that the death certificate igned by the attending physbe detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
quires that in signed bi	ed by Pr	Part II. Dther significant conditions cont	nbuting to death but not result of the sum o	Ilting in the u	ınderiying cause gıv	en in Part I.			to the cause of death? Probably 4, Hunknown
sician: The law requires the secriticate has been signed lirector, page 2 should be considered.	Completed	(24a. Was ar autopsy perform 1 Yes 2	24b. Were a prior to death?	autopsy findings available completion of cause of s 22 No
ician: certific rector,	Be	25. Was case referred to medical examiner?	spital:		- acino Oth	26. Place of Death			
or Attending Physiatter death. Director: After this lin by the funeral di	ation: To	1 Yes 22 No 12. 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	of 28c. Injur Wor	4 Mursing Ho		nca 6 □Other <i>(Sp</i> w injury occurred	өсігу)
tal or Atters all Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, si	reet, factory, offica		28f. Location (Str City or Town	reet and Number or I , State)	Rural Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical		cian: To the best of my knover: On the basis of examinat and manner stated.			pinion, death occurr	ed at the time, da		ue to the cause(s)
		30. Na e d ad ress of person who cor	npleted caus of death (Item	23a) (Type	Print) US	3640	. 27	14/401	72004
State	e	31. Date filed (Month, Day, Year)	32. Registrar's Signal	chila	historical i	30	s bal	Tim he	21259

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** William Clavell, Sr. 2004 July 24, 6:26 p Melvin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street and number) Examiner 4705 Middleburg Carrol1 Road Union Bridge 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 19, 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 🛣 M 2 🗆 F Months Days Hours Yrs. Director 65 Maryland 219-34-4866 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f show the Medical Execution count be notified at 1 ☐ Yes 2 ☐ No Directo Bridge Maryland Carroll Union 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4705 Middleburg Road 21791 U.S.A. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify. 3 ☐ Widowed 4 🖾 Divorced White "nstural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 is marked other it any injury or other traumatic event, the once. 7th Farmer Farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ressie George E. Clavell, Sr. Μ. Hare 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas T. Clavell Son 15918 Dark Hollow Road Upperco, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser. 7/26/04 Hampstead, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD tus 31. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death I imediate Cause (Final disease or condition resulting in death) Physician Myocardial Hours /Medical Due to (or as a consequence of): Examiner Years COYONDY Securatially fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be detached for use as the burial-transit The law requires that the death certificate be executed the attending physicien and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown þ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records. Obstructive Pulmonery 4 WUnknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3□ DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury s after dea... 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours at To the Funerel D pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 00059943 26,2004 b 30. Name and address of plason who completed cause of death (Item 23a) (Type, Print) 295 , M.D Stener 21157 MO

State Registrar

31. Date filed

32. Registrar's Signature

	1	For State Registrar	State of Marylan		artment of tificate of				giene Reg. No	2004	23713	
Physicia /Medica	ledical HAZEL ELIZASETH SPARKS MCCOM									Year 2004	3. Time of Death 10:20 a M	
Examine Funeral		4a. Facility Name (If not institution, give single 19726 Ginger Vie 5. Social Security Number 6. Sex	w Lane 7. Age (In yrs.	4b. City, Town, or Location of Death Annapolis (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.			r 24 Hrs.	B. Date of Birt	A.	nne Art 9. Bir		
Director		218-14-6514 Usual Residence of Decedent 10a. State 10b. County	M 2 XF 80	Yrs.	Months Day	s Hours	MIII.	Feb. 4,	,1924	Mar	y Land 10d. Inside City Limits	
he Maryla 28a-f shor	Director	(DV:										
leath with	Funeral Dir	2726 Ginger View I	2726 Ginger View Lane 1. Marital Status 12. Was Decedent Ever in U.S.				rigin? (Spec	U.S	U.S.A. 14. Race - American Indian,			
ours after or iter	2	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates:		fYes, specify Cu			ican, etc.)		Black, Whi		
filed within 72 hours after death with the Maryland Hygiene, uther then "naturel", or Items 23a or 28a-f show int, Ite Mudical Evandinar must be rediffed at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti istered	e during mo red)		g		nd of Business Spital	/Industry	
S d la D	To Be Co	17. Father's Name (First, Middle, Last) Walter		arks	,13tered	18. Moth		(First, Middle,		Sumame)	Wilson	
and 2 should ealth and Men n 27 Is marks er traumatic		19a. Informant's Name/Relationship (Type Cathryn L. Carroll	oe, Print) (Daughter)	19b. Mailir 2726	g Address (Stree Ginger	View I	ane A	nnapol	is,M	Town, State, aryland	Zip Code) 1 21401	
permit. Peges 1 and Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	amovai irom State	uid Rid	sition (Name of natory or other p. Ige Ceme	tery	7/26	/04	Pik	cation · City or esville	· Town, State e, Maryland	
permit. Depart Import any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 2121										
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications relation and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each role. Immediate Cause (Final disease or condition resulting in death) Due to (or as a const purpose of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, such as cardiac or respiratory arrest, and Death of the mode of dying, and Death										
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gne bed	þ	Part II. Other significant conditions con	given in Part	i.	23e. Did tobacco use contribute to the caus							
	Completed							24a. Was autop perfo 1 Yes		prior to death?	utopsy findings available completion of cause of	
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r Attending Phy er death. rector; After this by the funeral d	Certification:	27. Manner of Death Natural Character Street Street Street Stre	28a. Date of Injury (Month, Day Year)	Jaý Year) Injury Work? M 1 ☐ Yes 2 ☐ No			28d. Describe how injury occurred					
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun		4 Homicide determined	eet, factory, offic			City or Tov	vn, State)		ural Route Number,			
he Hosi in 24 ho he Fund pletely f	edical	(Check only 2 Medicel Examinate)	sician: To the best of my kno ner: On the basis of examina and manner stated.		vestigation, in my	y opinion, de	ath occurre	d at the time,	date and	place, and due	e to the cause(s)	
To To Conf	2	29b. Signature and title of certifier	claw, W.)	29c. Lice	307	129		29d. Date	signed (Mont	2004	
P		30. Name a address of person who co	mpleted cause of death (Item	п 23а) (Туре,		et. #	20. Thi	eson, t	tar vi	21 21	204	
Stat		31. Date filed (Month, Dey, Year)	32. Registrar's Signa	The second second	dra d	,	,	,	J			

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			Registrar	<u></u>	Cei	rtificate of	Death	2. Date of Deat	9 No. U 4	23/14		
	Physici /Medic		Decedent's Name (First, Middle, Last) George Russell	Cav					Day Year 2004	3. Time of Death		
	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or Location of Death			4c. County of Death			
		7 = 1	7506 Bel Air Road 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast hirthday)	Baltimore If Under 1 Year If Under 24 Hrs. 8, Date of 1			Baltimore 9 Birthplace (State or Foreign			
	Funeral Director			XM 2□ F 57	Months Days	Hours Min.	8. Date of Birth Month, Day, March 26	9. Birthplace (State or Foreign Country) Mary Land				
	yland		10a. State 10b. County		, Town or Lo	cation	-			10d. Inside City Limits		
	e Mar	ctor	Maryland Harford	В	aldwin					1 ☐ Yes 2 ☐ No		
	with th	Funeral Director	10e, Street and Number 2745 Greene Lane			10f. Zip Code		1	0g. Citizen of What C	ountry?		
	ns 23	eral		12. Was Decedent Ever in U.S	Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- !f Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14.				USA 14. Race - Am	erican Indian.		
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23e or 28e-f ehow other traumatic event, the Madical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 □ YNo If Yes, Give Year or Dates:					Black, Wh	ite, etc.		
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d 2	filed with Hygiene. other the		17. Father's Name (First, Middle, Last)	4	Business Manager 18. Mother's Name (First, Middle,				Sounds Soluti Maiden Surname)	tions		
all	id be lental ked c	To Be	William Russell Cavey				Margueri	te Dixon				
Baltimore, Maryland 21215-0036	and 2 should be ealth and Mental m 27 ie marked oner traumatic ever		19a. Informant's Name/Relationship (Ty, Jessica Cavey/Daughter	pe, Print)		ng Address (Street: Greene Lane	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)		
ore,	es 1 and of Health f item 27 r other tr		20a. Method of Disposition	cemetery, crema					20c. Location - City of	C. Location - City or Town, State		
Ë	Pages ment of I ant: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ H	emoval from State Hill	Itop Sei	rvice Corp. 7/27/04			Towson Maryland			
Balt	permit. Pages 1 a Department of Hee Important: If Item any injury or othe		21. Signature of Funeral Service Licensee Christina L Hilton Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214									
	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
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ital		BeC	25. Was case referred to medical examiner?		26. Place of Death							
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier ↑ Certifying Phys (Check only one) 2 Medicel Exeminate Medicel Exem	sicien: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death ion and/or in	n occurred at the tim vestigation, in my of	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner a ate and place, and du	s stated. a to the cause(s)		
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	o 7632	29	th. Day, Year) 2004						
	5		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, 2 il	Print)	JALK AV	E, E	BALTO 1	ND 21222		
	Sta	1.0	31. Date filed (Month, Day, Year)	32. Registrar's Signat	nte	l: - 1:	•					

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			For State	State of Mar	•	epartment of I Certificate of		_	00	OI.	22715		
			State Registrar	41		Jeruncale of	Dealli	2. Date of De	Reg. No.	Uth	3. Time of Death		
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i.	Funeral Director		219-18-3009	M 2□ F 7		Months Days		8. Date of Bir (Month, Da March	y, Year) 9,1926		ce (Stete or Foreign y) Sylvania		
	and and	1	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town o	or Location				100	d. Inside City Limits		
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	7.288	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Countr	ry?		
	within 72 hours after death with the Maryland ene. Itan "neturel", or Items 23a or 28a-f ahow Ita Medical Examirer must be rotitled at		651 South 48th	Street			21224		Unite	d Stat	es		
	dea	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of If Yes, specify Cub	pecify Yes or No to Rican, etc.)	14. Race - American Indian, Black, White, etc.					
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ב ב	Hys ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle,	iddle, Maiden Sumame)				
<u> a</u>	should be nd Mental marked c	ToE	Emilio Canneti					Mary A.	Amoriello				
~	d2 trail		19a. Informant's Name/Relationship (Mary Lou Hers1			Mailing Address <i>(Str</i> ee 10 Leslie		ural Route Numbe Baltimor			^{Code)} 21236		
w	- I = =		20a. Method of Disposition		20b. Place of D	hisposition (Name of crematory or other pla	ace)	Date	20c. Location	- City or Tow	m, State		
Ē	8 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☑ Other (Specify	Removal from State DEntombment		ns of Fait		28/2004	Balt	imore,	Maryland		
aĦ	permit. Pag Department Important: any injury c once.		21. Signature of Juneral Service Ligar			22. Name and Addr				*			
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	Physician		Immediate Cause (Final disease or condition	MYOCARDIAL INFARCTION UNKNOWN									
	/Medical Examiner		resulting in death)	Due to (or as a o	consequence of)								
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<u>ч</u>	hat th d by detach		Part II. Other significant conditions of	ontributing to death but i	not resulting in t	he underlying cause of	iven in Part I	23e. Did t	obacco use con	ntribute to the	cause of death?		
Vital Records,	The law requires that the tee has been signed by the rage 2 should be detached.	d by	,	3	.	,g		10	Yes 2□No	3 Probal	bly 4 Únknown		
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			25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only o		1 Yes 2	LI NO		
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jo	andin sath. or: Af	atio	1 Natural 5 Pending 2 Accident investigation	n 1 □ Yes 2 □ No									
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	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,			ysician: To the best of									
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	ID		30. Name and address of person who			0	1.00	^^ 17	M I'm a	en 4.4	٨		
			31. Date liled (Month, Day, Year)	1 INDKADE	·	600 NOR	TH WOU	rt D	ALTIMOR	E M	ν		
	Sta Registi		JUL 28	32. Registrar's	wa	& door	de .						

CALTAGIRONE, ERMA

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

			1. Decedent's Name	e (First, Middle, La	st)					2. Date of Dea	ath	3. Time of Death
	Physic		Erma Messina Caltagirone							July	Day	ear 100 A.M.
	/Medi				e street and number			4h Cihi Taum	and continue of De		24 26	04 1
7	Exami	ner		-	\ L	1	n /	46. City, Town, o	or Location of De		4c. County of	
			Frankl	in Squ			AC	ROSE	DALE			h more
	Funeral		5. Social Security N 217-92-0		Sex 7. A □ M 2√√F	Age (In yrs. Ia 85	**	If Under 1 Year Months Days	If Under 24 H Hours M		h y, Year) 9	Birthplace (State or Foreign Country)
	Director				×x.	85	Yrs.			March 1	2,1919 Wa	shington DC
	pu .		Usual Residence of 10a. State	10b, County		100 City	Town or Le	anation				1011 11 01 11 1
-	aryla sho	<u>.</u>		· ·								10d. Inside City Limits
	9 Mg	cto	Mary1and	Baltimo	ore	Di	ındal)	ζ				1 ☐ Yes 2 🛣 No
	or 28	Directo	10e. Street and Nur	mber				10f. Zip Code			10g. Citizen of Wha	at Country?
	h wi		7708 Wy	nbrook Ro	ad			21224		U	nited Sta	ates
	deat	Funerai	11. Marital Status	• • • • • • • • • • • • • • • • • • • •	12. Was Deceder	t Ever in U.S	. 13.			(Specify Yes or No- erto Rican, etc.)	14. Race -	American Indian,
ယ	after or Ite	T.	1 Never Marri	ed 2 Married	Armed Forces					erto Hican, etc.)	Black,	White, etc.
Maryland 21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or Itema 23a or 28a-f show he Medical Everbiner man be notilied at	by	3 🖾 Widowed	4 Divorced	If Yes, Give Year or Dates	:		1 ☐ Yes 2 🙀 No	Specify:		Specify: V	Mite
Ō	2 ho	Completed		15. Decedent's Ed	ducation		16a. Dece	dent's Usual Occup	pation		16b. Kind of Busin	ness/industry
7.5	n n	pie		ify only highest gra		5.3	(Give life.	kind of work done DO NOT use retire	during most of w d)	vorking		,
7	with in the	E	Elementary/Seco	ndary (0-12)	College (1-4o	5+)	Home	e Maker			Own Ho	am a
0	filed Hyg the	O	17. Father's Name	(First, Middle, Last))		HOME	Haver	18. Mother's N	lame (First, Middle,		nie
an	od be of control	Be	Loonand	Lee Well	_					E. Waylan		
> ≥	a Me	To		me/Relationship (401 11 11					
a	2 sl an is r									Rural Route Numbe		
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I the file m 21 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Eventiner must be notified at			y Hager/D	augnter				Road Ba.	ltimore,	<u> </u>	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Meonce.	l i	20a. Method of Disp		Removal from Stat		ice of Dispo metery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - Cit	y or Town, State
Ē	Pag ment ant:			5 Other (Specif		Garı	rison	Forest V	et dem '	7/28/2004	Owings M	Mills, Maryland
ä	mit. partr ports / Inji		21. Signature of Fu	neral Service Licer	nsee		2	2. Name and Addre	ss of Facility			
) 🛱	Pe de la companya de		Att	phriee	mass	eix				1 Home of		
			23a. Part1. Enter t	ne disease, or com	plications that cause	ed the death.	Do not en	er the mode of dying	ng, such as card	Dundalk,	- Mary Lanc rest,	Approximate
			shock, or hea Immediate Cause (-	one cause on each	line.	1					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	'n	a U · U)	<u>D</u> .					
	Examiner			- (Due to (or a	s a conseque	ence of):					
		<u>.</u>	Sequentially list con	nditions,	b							
VI	pe #s	Examiner	Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or	rlying	Due to (or a	s a conseque	ence or):					
	and tran	an	that initiated events resulting in death) I		c							
Ő,	be executed sician and burial-transit		rosaning in doarny t		Due to (or a	s a conseque	ence of):					
68760,	ate Ye be	an/Medical			d							
99	leath certifica attending ph I for use as t	Jed	IE EENAL C.									
Вох	h ce	Z.	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcom			Ectopic pregnance			23d. Date of	f delivery
<u> </u>	deat e atte d for	Ç	in the past 12 1 Tes 2	7	4□Pregnant:			Other (specify)	y 		Month	Day Year
P.0	The law requires that the de ste has been signed by the s bage 2 should be detached	hysi	9 🗆 Unknown		9□ Unknown							
	that hed b	by Pl	Part II. Other signif	icant conditions o	ontributing to death	but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did to	b o use contribu	te to the cause of death?
ds	uires I sign	q p								1,96	es 2 □ No 3 [☐ Probably 4 ☐ Unknown
Ö	w requ	Completed								-		
ec	has has	ldu								24a. Was a autop:	n 24b. Wer	e autopsy findings available r to completion of cause of th?
=		Co		,						perfor	med? deal	th? Yes 2□No
ita	ii cian : Th certificete rector, pag	Be	25. Was case reference examiner?	red to medical					26. Place of D	eath (Check only or	10)	
Division of Vital Records,	d is	으	1 □ Yes 2 □	r/o	Hospital: 1 Inpat	ient 2 E	R/Outpatier	it 3 DOA Oth	er: 4 Nursing	Home 5 Resid	ence 6 Other (Specify)
0	ig Ph ter th neral		27. Manner of Deatl		28a. Date of Inj (Month, D	ury 2	8b. Time of	28c. Injur Wor		7	ow injury occurred	
Ö	Attending death. ctor: Aft y the fun	atio	1 ✓ atural 2 ☐ Accident	5 Pending investigation		ay rour)	injury		Yes 2 No			
S	Atte	ific	3 Suicide	6 Could not be determined	28e. Place of Ir	njury - At hom	e, farm, str	eet, factory, office		28f. Location (S.	treet and Number o	r Rural Route Number,
ā	- e e	Certification:	4 Homicide		building, e	itc. (Specify)				City or Tow	n, State)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ai C	29a. Certifier	1 Certifying Ph	ysician: To the bes	t of my knowl	edge, deatl	occurred at the tir	ne, date and nia	ce, and due to the o	ause(s) and manage	or as stated
	24 h Fur	edicai	(Check only one)	2 Medical Exan	niner: On the basis and manner s	of examinatio	n and/or in	vestigation, in my o	pinion, death oc	curred at the time, d	ate and place, and	due to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and	title of certifier	and mained s			29c. Licens	e number	2	9d. Date signed (N	fonth Day Year)
	F 3 F 8			. 011	0 -	_		0-			n . I	h (6 1 1
	1		-//	MUM	Val			KE	0000	00 1	Wy 24	12004
	6		30. Name and addr	ess of person who	completed cause of	death (Item 2	3a) (Type,	Print)	0	1	J	
	ン		UR. HOS	SeINP	raena	11-6	1000	trankl	IN SQL	uppe Dr	ve BAH	imore, UD. 21237
	Sta	te	31. Date filed (Mont		_	trasis Signatu	re	4 1				
	Registr	ar		JUL 2 8	2004 🕨	Dener	- /	O DO	els!			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			Please	Type or Prir					-		_	
			1 - For Stete Registrar	State of Ma	aryland	•	artment of F rtificate of	lealth and I Death	Mental H			
			Decedent's Name (First, Middle, La.	st)			timouto or		2. Date of D		. 004	3. Time of Death
	nysici Medic		ALBERT C. DEL B	IANCO					JULY	Day 25	2000	3:40 AM
	xamin		4a. Facility Name (If not institution, give	il an a 'la	71		0 11	or Location of Death	,)		County of Death)
Cur	neral		5. Social Security Number 6. S		e (In yrs. Ia	st birthday)	If Under 1 Year	MOVE If Under 24 Hrs.	8. Date of B		NA 9. Birth	place (State or Foreign
	ector		171-07-4631	X M 2□F	86	Yrs.	Months Days	Hours Min.	(Month, E	irth Day, Year) 1917	Cot	NSYLVANIA
and			Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
Maryi	flexi a	tor	MD BALTI	MORE	F	RIDGEL	EIGH					1 ☐ Yes 2 🕅 No
th the	N LO	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	intry?
ath w	MALL		8507 OAK ROAD	10.14				234			USA	
fter de	IDEL	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ X Married	12. Was Decedent Armed Forces? 1 Xes 2 1		i. 13. \	Was Decedent of F f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	10-	 Race - Amer Black, White 	
C Z IZ IS-UUGO filed within 72 hours after death with the Maryland Hygiene. ther than "netural" or Itams 23e or 28e-f show	Exac	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 X No	Specify:			Specify:	WHITE
72 h	edica	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)		(Give	tent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	16b. Kir	nd of Business/I	ndustry
Z within	The M	omp	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5	+)		LANE MEC			GLEN.	L. MART	TN
al Hyg	went,	Be C	17. Father's Name (First, Middle, Last)		- '			18. Mother's Nam		e, Maiden		
should be not Mental	natica	To	JOSEPH DEL BIANC	- 1,5mm m				JOSEPHI				7.
DENITIFICITY, INITIFICITY A LETS-10-000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Menlar Hygiene. Important: If time 27 is marked other than "netural; or Itams 23e or 28e-f show	traun		19a. Informant's Name/Relationship (ANN B. DEL BIANC		Έ			and Number or Ru D BALTIM			. Town, State, Zi 234	p Code)
itam	other		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other place		Date	7	cation - City or T	own, State
mit. Pages partment of 8	ury or		1 □XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif				F FAITH		29/2004	PAR	KVILLE,	MD
permit. Departr	eny inj once.		21. Signature of Funeral Service Licer	ISOP /				ess of FacilityTHE				· .
			23a. Part. Enter the disease, or com	plications that caused	the death.			RAVEN BL	or respiratory	DWSON,	, MD 21	1286 Approximate
Physi	cian		Immediate Cause (Final	one cause on each lin	10.	61	nock					Interval Between Onset and Death
/Med	dical		disease or condition resulting in death)	Due to (or as	conseque	ence of):	100 -					
Exam	illei	e	Secuentially list conditions	b. Comple	to t	tellut	GOCK					
uted	ansit	Examine	Sacurations list can differ sif any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Munca	vid. (6	U 111	favatio	M			Į.	
e executed sian and	rial-tra		resulting in death) Last	Due to (or as	a conseque	ence of):	100000	,,				
DIVISION OF ITALE AND A PARTICIAN. The law requires that the death certificate be titing 24 hours after death.	detached for use as the burial-transit	dical		d								
certific	JS 9 as	hysician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	cy				2	3d. Date of deliv	An/
death	od for 1	iciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			Ectopic pregnancy Other <i>(specify)</i> _	·		-	Month	Day Year
at the	etache	Phys	9 Unknown	9□ Unknown								
ires th	should be detached f	by	Part II. Other significant conditions of	ontributing to death bi	it not result	ting in the ur	iderlying cause giv	ren in Part I.			se contribute to t]No 3∏Proi	he cause of death?
w requir been si	shoul	letec							24a. Wa:			
The la	- 4	Completed							auto		prior to co death? 1 \(\sum \text{Yes}	opsy findings available impletion of cause of
cian: entifica	actor, p	Bec	25. Was case referred to medical examiner?					26. Place of Dea			7 4 163	2010
Physi this c	ral dire	٦.	1 Yes 2 No	Hospital: 1 Inpatie		R/Outpatien 28b. Time of		4 Nursing H	ome 5 ☐ Res		Other (Specia	(y)
ading P	eunj e	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe	now injury	occurred	
r Atta	by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At hom	ne, farm, stre	et, factory, office		28f. Location	(Street and wn, State)	Number or Rura	al Route Number,
pitelo urs aft	illed in		200 00000000000000000000000000000000000									
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A	completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examinatio	nedge, death on and/or inv	estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time.	cause(s) a date and p	and manner as s place, and due t	tated. the cause(s)
To the within To the	compl	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
, 1			sheare	MD			Re	5000		Jul	4 27	2004
140			30. Name and address of person who	completed cause of de	ath (Item 2	23a) (Type, I	Print)	5 000 Blud, 12	relibias	000	hat?	21120
*	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ur's Signatu	Ire_	MUCH !	2100, 12	CILLIVA	uie,	IVIU	404
Re	egistr	-	JUL 2 8 2004	Berein A	y M	best	,					

William Frank UNK 04256	(1 :	in Dudley Please T	ype or Print in	Black In	delible Ink	. Ensure A	ll Copies	Are Legi	ihle	
04-04801 RJ		For Unpend Ttem					-	_	 .	
Tio Tio		1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Ce	rtificate of	Death	2. Date of De	F 10)4_	2 3 7 1 8 3. Time of Death
Physicia /Medic		,	ı F. Dudley				July 2	4, Day 2004	Year	12:53 A.M
Examin		4a. Facility Name (If not institution, give s	street and number)			or Location of Death		4c. County	of Death	
Funeral		Franklin Square Ho 5. Social Security Number 6. Sex		. last birthday)	Roseda		8. Date of Birt			County ace (State or Foreign
Director		218-76-9693	M 2□F 4	Tall 1	Months Days	Hours Min.	8. Date of Birt (Month, Da Jan29	ÿ, Υθαr) , 1 955	Count	1and
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation		11-		10	Od. Inside City Limits
36 s after death with the Maryland or thems 23a or 28a-1 show	ctor	MD Baltim	ore	I	Essex					1 ☐ Yes 2 🛣 No
with th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	try?
death ms 23	Funeral	41 Seaford Av	12. Was Decedent Ever in U	J.S. 13.		21221 Hispanic Origin? (Sp	ecify Yes or No-	USA 14 Rad	e - America	an Indian
<u> </u>	y Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give		f Yes, specify Cub 1 □ Yes 2 🛛 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		ck, White, e	etc.
	ed by	3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occur			16b. Kind of B	White	
215 thin 72 an "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work od)	ring			,
4 21 iled wi tygien ther th		12th 17. Father's Name (First, Middle, Last)		Cont	rol Eng		- Cina Middle	Gray&		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygient in Insture!, or any injury or other traumatic event, the Madical Exampance.	To Be	Jack Dudley				18. Mother's Name		Maiden Suman	16)	
Taryla 2 should I and Men and Men Is marka	-	19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Street	and Number or Rura		ar, City or Town,	State, Zip	Code)
e, N 1 and 3 1 ealth 9m 27 ther tr		Beverly Kozlow 20a. Method of Disposition			Seaford	d Ave. B	altimo:		0: -	
altimore, mit. Pages 1 ar partment of Hea portant: If item : y injury or other ce.		1 ☐ Burial 2 ★Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crer	natory or other pla	ce)		20c. Location	•	
Baltir Permit. F Departme Importan any injur		21. Signature of Funeral Service License	1986			ess of Facility Cor		Balti:	Home	ofFeee
ഥ ឧ≙≣ឱឱ	1 10	K. Terry	onnell	\mathcal{G}	_300 Ma	ce Ave.	Baltin	nore MI	212	221
		23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final				ng, such as cardiac (or respiratory ar	rest,		Approximate Interval Between Onset and Death
Pnysician /Medical		disease or condition resulting in death)	Cocaine Int		LON					
Examiner	_	Sequentially list conditions,	·						==5	
rted Insit	xamine	if any, leading to immediate cause. Enter Underlying Cause (Unsease or mounty that initiated events	Due to (or as a consec	quence of):						
O, s executed an and rrial-transit	ш	resulting in death) Last	Due to (or as a consec	quence of):						
Records, P.O. Box 68760, The law requires that the death certificate be extended because a second for use as the burian age 2 should be detached for use as the burian	Physician/Medical									
Box 68 eath certifics attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregn	ancy				22d Dat	e of deliver	
O. B.C. in deep the deep the attention hed for u	iciar	in the past 12 months?	1 Live birth 2 Feta		Ectopic pregnancy Other (specify)	у		Moi		y Day Year
P.O. that the debate bed by the detached	Phys	9 ☐ Unknown Part II. Other significant conditions con	9☐ Unknown	nuthing in the co		in Book	00 - Did -		de a a a al	44.40
'ds, P	d by	Part II. Other significant conditions con	mouning to death but not res	suiting in the ur	iderlying cause giv	ren in Part I.		es 2 🗆 No		cause of death?
aw requir	plete						24a. Was a	an 24b. V	Vere autops	sy findings available pletion of cause of
The tav	Completed						autops perfor	mea? c	rior to compleath? Yes 2	
of Vital F Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Death		ne)		
9 Physer this leral dil	\vdash	27. Manner of Death	28a. Date of Injury Fourth, Day Year)	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injur Wor	4 Nursing Hor	me 5 🗌 Reside 28d. Describe he			
Vision (Attanding I r death. sector: After	catlo	1 Natural 5 Pending 2 Accident investigation	7/24/04	Found 12:07	A ^M 1□	Yes 2 XNo	Unknown			
Division of Vital Records, for Attanding Physician: The law requires talter death. Director: After this certificate has been signed in by the funeral director, page 2 should be or	Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special Found: outs	ome, farm, stre fy) ide of	et, factory, office	D	28f. Location (Si City or Town	treet and Number, State	Back I	River Neck t y, Maryla
# S # S # S # S # S # S # S # S # S # S		29a. Certifier 1 Cartifying Phys	ician: To the best of my kno	owledge, death	occurred at the tir	The date and place of	and due to the c	ause(s) and ma	000100000	and
the H thin 24 the Fi mplete	Medical		ar: On the basis of examina and manner stated.	ation and/or inv						
or with	_	29b. Signature and title of certifie	on M	1	29c. Licens		2	9d. Date signed. July 2		
		30. Name and address of person who cor	npleted cause of death (Iter	п 23a) (Туре, I	Print)					
		S, Z, HOGA 31. Date filed (Month, Day, Year)	1 NO.	atura.	111 Peni	n Street,	Baltimo	ore, Mar	yland	21201
Stat Registra		JUL 2 8 20	32. Registrar's Signa		and					

THONY DORS	EY	State of Maryland 1 Department 1 - State Registrar Amend item/7 per FH, C833 Certificate	of Health and M of Death		ene	23719
Physicia	n	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
/Medica Examine	1	3511 SPALITUTNIC AVENTIE	own, or Location of Death		22, 2004 4c. County of Deati N/A	11:07 A ^M
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1		8 Date of Birth		nplace (State or Foreign untry) aryland
and ww	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
the Marylan r 28a-f show	io	Maryland N/A Baltimore				Y Yes 2 □ No
	ai Director	10e. Street and Number 3511 Spaulding Avenue 10f. Zip Co	ode 1215	10g	g. Citizen of What Co	untry?
urs after	d by Funerai	1 Never Married 2 Married 1 Tyres 2 No 19/8 =	nt of Hispanic Origin? (Spe Cuban, Mexican, Puerto No Specity:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B]	e, etc.
within 72 ene.	Completed	College (1-4or 5+)	done during most of worki retired)	ng	Sb. Kind of Business/l	
be file had the avant	lo Be C	12th grade 17. Father's Name (First, Middle, Last) Alder Dorsey		(First, Middle, Ma		,
Alary 2 sho and h is ma			Street and Number or Rura			
en 1 an Heal		Claudia Davis Brothers/Sister 3511 Si 20a. Method of Disposition Dispurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Claudia Davis Brothers/Sister 3511 Si 20b. Place of Disposition (Name cametery, crematory or othe Carrison Force)	of 7/28/	04 20	c. Location - City or 1	Town, State
Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe	İ	21. Signature of Funeral Service Licensee 22. Name and A	Address of Facility Cha eisterstow	tman-Ha		eral Home
S8760, Iterate be executed behavioral Examiner and burial-transit sithe burial-transit	dical Examiner	29a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Civer Civer Si's Due to (or as a consequence of):	emerrha	je		Interval Between Onset and Death
Box (Bath certif attending for use a	Pnysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregrant at time of death 5 ☐ Other (special pregnant at time of death 5 ☐ Othe			23d. Date of delik Month	very Day Year
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
The lay ate has page 2	Completed by			24a. Was an autopsy performer	d? prior to co	opsy findings available ompletion of cause of
n of Phys rear this neral dii	Certification; 10 be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident investigation 3 Suicide 6 Could not be	26. Place of Death Other: 4 Nursing Hor Injury at Work? 1 Yes 2 No			ity) AT SCENE
DIVI		4 Homicide determined 256. Place of injury - At nome, farm, street, factory, of building, etc. (Specify)		City or Town, S		
Division To the Hospital or Attending I within 24 hours after death. To the Funarel Director: After completely filled in by the funarel Director.	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at t XXMedical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurre	ed at the time, date	and place, and due t	to the cause(s)
To with To conn	4		O.C.M.E		Date signed (Month, JULY 23,	Day, Year) 2004
7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZHSI LICCH H A L 111 Penn Street	et, Baltimor	e, Maryl	and 21201	
State Registra		31. Date filed (Month, Day, Year) JUL 2 8 2004 32. Registrar's Signature	els			

			1 - For State Registrar	State of M	-	epartment of Certificate		and Mental Hy	giene	23720
	Physici	an	1. Decedent's Name (First, Middle, Last	,			70"	2. Date of De Month	Day Yea	
	/Medic Examir		Amedeo Fulvio 4a. Facility Name (If not institution, give	DeFeo)	4b City Toy	vn, or Location of	July	4c. County of De	
	Exami	lei	Saint Joseph N			lo. o.ly, vo.		wson		timore
	Funeral Director		111 32 1370	x 7. Ag	ge (In yrs. last birtho 63 Yrs	Months Da	ear If Under ays Hours	Min. 8. Date of Bir (Month, Da June 2	th year) 9. B 8, 1941 New	irthplace (State or Foreign Country) WYORK
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	e Man ta-fsh tiffed	ctor	Maryland Baltimo	<i>ie</i>		Bal	timore			1 ☐ Yes 2 XNo
	with th	Funeral Director	10e. Street and Number	2		10f. Zip Co			10g. Citizen of What (Country?
	Jeath ris 23	eral	1807 Glen Ridge	12. Was Decedent	Ever in U.S.		21234	nin? (Specify Yes or No	U.S.A. 14. Race - An	neocan Indian
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel; or items 23e or 28a-f show shy injury or other treumetic event. I're Marical Exarting must be natified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【X Divorced	Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	No	If Yes, specify (gin? (Specify Yes or No , Puerto Rican, etc.)	Black, Wr	ite, etc.
20	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. De	cedent's Usual Ocive kind of work do	ccupation	of warking	16b. Kind of Busines	s/Industry
2121	giene.	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4or	5+) <i>lif</i>	e. DO NOT use re itation l	etired)		Sanitatio New Yor	
Baltimore, Maryland 21215-0036	ild be file lental Hy rked oth	To Be (17. Father's Name (First, Middle, Last) Carmine DeFe	20			18. Mothe	r's Name (First, Middle, ÚL Delc	Maiden Surname) OSTELLO	
lary	2 shou and M is mai		19a. Informant's Name/Relationship (T)				reet and Numbe	r or Rural Route Numbe	er, City or Town, State,	Zip Code)
e, ≥	1 and 1ealth sm 27 ther tr	- 9	Mr. Francis X. Au 20a. Method of Disposition	ena (nepl	Annual Control	98 Oakmov sposition (Name o	rt Road,	Fallston,		_
nor	ages int of h t: If ite	- 33	1 ☐ Burial 2 【X Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, c	rematory or other Cremato	place)		20c. Location - City o	
ij	mit. P partme sorten r injury		21. Signature of Funeral Service Licens	98	bayorea			/31/04 Schimunek	Eunoral Ho	Maryland
<u>~</u>	Depar Depar Impor eny ir		* Eller from			9705 Be	elair Ro	l., Baltimo	re, MD 212.	36
	Physician /Medical		23a. Part1. Effer the disease, or compl shock, the heartfajure. List only or Immediate Lause (Paral disease or condition resulting in death)	Respir	d the death. Do not ne. atory Fa a consequence of):		dying, such as	cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
8760,	physician and physician and si the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a 11 Ce11 a consequence of):	Lung (Dancer			
.O. Box 6	ath certif uttending or use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregna 5 □ Other (specify			23d. Date of de Month	olivery Day Year
ď.	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions cor				-	23e. Did to	bacco use contribute t	o the cause of death?
ä	w require been sig should b	ted	IDIOPATHIC INTER	STITIAL I	PULMONARY	FIBROSIS	5	1 U Y	'es 2 No 3 □ P	robably 4 Unknown
al Records,		Completed						24a. Was autop perfor 1 Yes	sy prior to	utopsy findings available completion of cause of
Vital	sicien: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?	lospital: 🏒	all spin		04	of Death (Check only or		
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification properties to the funerel director, sompletely filled in by the funeral director,		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. D. te of Inju (Month, Day	ry 28b. Time	of 28c. I	4 ∐ Nur njury at Work? I □ Yes 2 □ N		ence 6 Other (Special own injury occurred	ocify)
DIVIS	el or Attendi s after death. Il Director: A id in by the fu	Sertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, c. (Specify)	street, factory, offic	сө	28f. Location (S City or Town	itreet and Number or R n, State)	ural Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	sician: To the best of ner: On the basis of and manner sta	examination and/or	ath occurred at the investigation, in m	e time, date and ny opinion, death	place, and due to the conoccurred at the time, of	ause(s) and manner as late and place, and du	s stated. e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	_		29c. Lice	ense number	2	29d. Date signed (Mont	/
	0,	-	1 Dan		ac	D 3	30263		7/27/0	7
	1		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Typ	e, Print)				
	Sta	te	Trancis Khoo M 31. Date filed (Month, Day, Year)	32. Reg 1761	ZL1 Osler ar's Signature	Drive	Towsor	, Maryla	nd 21204	
	Registra		JUL 2 8 2	004 Jac	en &	provide				

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) J Month Physician THELDA 8:00 PM EVERHART 22, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA BALTIMORE UNIVERSITY OF MAKYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 M 71 Director Sept. 24, 1932 Tennesse 413-52-2999 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore 1 ☐ Yes 2 No Director Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 202 Midlass Drive death 21220 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainmain. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Carver Maggie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Finnerty /daughter 13 Tinker Road Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ty⊋yourial 2 ☐ Cremation 3 ☐ Removal from State 7/27/04 Baltimore MD HollyHillCemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Connelly Funeral Homeof Essex 21. Signatura of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. Part1. Enter the disease, or comshock, or heart failure. List only blications that caused the death—De not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician an/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Yes 2 No 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of al or Attending P after death. I Director: After t 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation М filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 2 🗆 one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 15870 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene 22 St. Baltimore, MD 21201 Kisse! 32. Registrar's Signature State Registrar

				1 - For State Registrar		State o		nd / Depa	artmen	t of H	lealth and I	Mental Hyg	iene g. No. 0 0 4	23722
	ı	Physici	ian	1. Decedent's Name (First, M			_					2. Date of Dea Month	Day Year	3. Time of Death
		/Medio Examir		VANCY 4a. Facility Name (If not instit		ASTE, street and nu			4b. City,	Town, or	r Location of Death		4c. County of Death	
				MARYLAND			ospita				lore, Me	d.	BACHIN	ore Csty
		Funeral Director		5. Social Security Number 216-306529		х] м 2 \Т F	7. Age (In yrs.	7 3Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day SEPT. 17	9. Birth Cou	place (State or Foreign intry) SC
		land bw		Usual Residence of Deceden 10a. State 10b. Con			10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
		the Marylar 28a-f show	ţō	MD	NA			BA	LTIMO	RE				1 X Yes 2 No
		or 28	by Funeral Director	10e. Street and Number					10f. Zip			1	0g. Citizen of What Cou	intry?
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5	215-	within 72 hours after death with the Maryland sne. than "natural", or items 23e or 28e-f show re Madical Exemirer must be notified at	Be Completed	(Specify only hi		e completed)	4.45.3	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occup rk done d se retired	ation during most of world)	king	16b. Kind of Business/Ir STATE	
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_	and	d la d	Be	17. Father's Name (First, Mid								ne (First, Middle, I	Maiden Surname)	
5	aryl	2 should I and Men is marker aumatic	T _o	19a. Informant's Name/Relat		rpe, Print)		19b. Mailir	ng Address	(Street	IDA and Number or Ru	LYLES ral Route Number	, City or Town, State, Zi	p Code)
+	ž	r 27 gr		GEWNDOLYN FEA	STER	(DAUGH		3702			OINT ROA		LLSTOWN, MD	21133
2	ore	00-		20a. Method of Disposition 1 X Burial 2 ☐ Cremati			State	Place of Dispo cemetery, crei	natory or o	ther plac	(8)	111	20c. Location · City or T	own, State
12	altimor	permit. Page Department of Important: if any injury or once.		° 4 ☐ Donation 5 ☐ Other			BA	LTIMORI		ALCOHOLD SECTION			BALTIMORE, I	
	B	Dermi Depar Impor any ir		Manak	-/1	14///	12-				LMOR STR		IMORE, MD	21217
				23a. Part1. Enter the disease shock, or heart failure.	or compl List only or	ications that	caused the deat	h. Do not ent	er the mod	e of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	8	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		d	pirati		Fai	lure	ك			Onset and Death
_		Examiner				F	(of as a consec	uenc a of):	Re	100	Disc	350		
		Po is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	1	Due to	(or as a conseq	uence of):	L) Y	The Lat.				
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/\	68 89	n certifical inding phy use as th		IF FEMALE:										
	Вох	leath certif attending I for use as	Physician/Med	23b. Was decedent pregnant in the past 18 months?	2	1 Live I	tcome of pregna pirth 2 ☐ Feta nant at time of c	Ideath 3	Ectopic pr				23d. Date of deliv Month	ery Day Year
	P.O.	that the do ed by the detached	hysi	1 □ Yes 2 No 9 □ Unknow		9□ Unkn	own							
	Division of Vital Records, I	se ng eq	by	Part II. Other significant con	ditions cor	ntributing to d	eath but not res	ulting in the u	nderlying c	ause give	en in Part I.		pacco use contribute to t es 2 □ No 3 □ Prof	_
	eco	e law requir has been s je 2 should	Completed									24a. Was a	v prior to co	opsy findings available impletion of cause of
	ain	ding Physician: The h. After this certificate hi funeral director, page		05.11/-	6							perform 1 Yes 2	1 ☐ Yes	2 No
	Z.	ysicia. is certi directo	To Be	25. Was case referred to medexaminer? 1 Yes 2 No	-	lospital:	Impatient 2	ER/Outpatien	nt 3□ DO	Othe		th (Check only on ome 5 □ Reside	e) ince 6 □Other <i>(Speci</i> i	fv)
	0 0	ing Ph	on: 1	27. Manner of Death 1 ☑Natural 5 ☐ Pe	ndina	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		8c. Injun			w injury occurred	,,
	isio	ttendi death. ctor: A / the fu	icati	2 Accident inv	estigation uld not be	28e Place	of Injury - At h	ome farm str	M eet factory		Yes 2□No	28f Location (St.	reet and Number or Rura	al Route Number
	<u>></u>	s after ai Dire	Certification;	4 Homicide de	ermined	build	ing, etc. <i>(Specil</i>	y)	ooi, idolory	, omoa		City or Town	, State)	ar riodia ridinoar,
		To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi	edicai	29a. Certifier 1 Cert (Check only 2 Medi	fying Phys cal Exami	ner: On the b	e best of my kno asis of examina ner stated.	wledge, death tion and/or in	n occurred a vestigation,	at the tim in my op	ne, date and place, pinion, death occur	, and due to the ca rred at the time, da	use(s) and manner as s ate and place, and due t	stated. the cause(s)
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	\	\		30. Name and address of per	ON	SIL	nala	/ V/_	V F	89	001	2	Uly 25,	2004
	ì	۸		Mabrook	S	heha	ata mean men	4) (Type,	0/0	1	ary lau	nd G	reneral	Hospital
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		Registr	ar	JUL	282	2004	Little St.	15	Break					

K.5	3		Please '	Type or Prii	nt in Blacl	k Indeli	ble Ink.	Ensure /	All Copies	Are	Legible.	
	ENRICO		_ For	State of M	aryland / D	epartm	ent of H	lealth and	Mental Hy	giene		
			1 State Registrar			Certific	cate of	Death		Reg. No.	004	23723
			Decedent's Name (First, Middle, Las	t)			_		2. Date of De	ath		3. Time of Death
	Physici /Medic		ENRICO		FAN	NI			JULY	24^{Day}	2004 2004	0933 A M
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-		Na Na	138 SOUTH BOULD					MORE CIT				
п	Funeral		5. Social Security Number 6. Se	x 7.Ag XXM 2□F	e (In yrs. last birt 82	Yrs. If U	nder 1 Year ths Days	Hours Min	. (Month, Da			nplace (State or Foreign untry)
	Director		214-12-2614 Usual Residence of Decedent		04				Aug 2	25, 1	921 17	ARY/AND
	yland		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	a-fsl	ctor	MARVIAND		BAlti	MORC						1 X Yes 2 No
	or 28	Dire	10e. Street and Number	2 1 1			f. Zip Code			10g. Citi	zen of What Cou	•
	ath w	Funeral Director	138 South 7		Stree	<i>></i> †		1224			U.5. A	
	er de Items	nne	11. Marital Status	12. Was Decedent Armed Forces?		13. Was D If Yes,	ecedent of H specify Cuba	lispanic Origin? (S an, Mexican, Pue	Specify Yes or No to Rican, etc.)	-	 Race - Amer Black, White 	
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔏 If Yes, Give Year or Dates:	NO	1 ☐ Ye	es 2 No	Specify:			Specify: \(\lambda\right)	hite
5-0036	72 hours after death with the Maryland natural', or Herns 23a or 28a-f show Jisal Exart actinuit te Dollin of at	ted	15. Decedent's Ed	ucation	16a.	Decedent's	Usual Occup	ation		16b. Ki	nd of Business/I	ndustry
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y B	nould be d Mental narked o	70	19a. Informant's Name/Relationship (7	Orient 515				TASO	QUALIN.	A		ip Code) 21222
Maryland	d 2 sho th and 7 Is ma trauma		ANGELA D	Domen		03 (Pealt.		urai rioule Numbe	or, city o	215 A	WARK MD
	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other then. or other traumatic event, the Medical Examination in retination and or other traumatic event, the Medical Examination is a retified at		20a. Method of Disposition	DUMEN	20b. Place of	Disposition	(Name of		Date		cation - City or T	
Baltimore,	Pages nent of l int: If its iry or o		1 Surral 2 (Cremation 3 D		PACI	y, crematory	or other place	10 V Ju	V 29 200d	B	alt ima	RO MARYING
Ħ	그 는 후 등		21. Signature of Funeral Service Licen		17(10)	22. Nam	ne and Addre	ss of Facility	1-12007	7	2 6000	enal Home
m	Depar Impor any ir		1/1/20	unins	_	703	seph 5.	N. ZA.	ING ST	: 3	4/10 M	re, MARYLAN ERAL HOME LD 21224
	٨		23a. Part1. Enter the disease or composition of heart failure. List only of	lications that cause one cause on each li	the death. Do r	ot enter the	mode of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
5	Physician		Immediate Cause (Final disease or condition						ion D	0	1355	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	C4-14-1	10.0	, ., ,	1 3 4		
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687	death certificate I e attending physi id for use as the b	Physiclan/Medic		J								
Вох	th cer endin r use	an/N	23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3∏Ecton	oic pregnancy	,		2	23d. Date of deliv	
	0 0 0	sick	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant a 9□Unknown			r (specify) _		-		Month	Day Year
P.0	The law requires that the de ate has been signed by the a bage 2 should be detached	Phy	9 Unknown						02- Did 1			the serves of death?
JS,	res the signer	by	Part II. Other significant conditions of	ontributing to death b	out not resulting in	i the underlyi	ing cause giv	en in Paπ I.		obacco u Yes 2[the cause of death?
oro	w raquire been sig should b	eted										
Records,	e law has t	Completed							24a. Was autop		24b. Were aut prior to co	opsy findings available ompletion of cause of
a									1 Yes	2 No		2 No
Vital		Be c	25. Was case referred to medical examiner? 1 XYes 2 No	Hospital:	A [58/0		Oth	er	ath (Check only o		170	** AE COENTE
of		n: To	27. Manner of Death	28a. Date of Inju	ent 2 ☐ ER/Ou lry 28b. T	ime of	28c. Injur Wor	4 Nursing	Home 5 Resident			ify) AT SCENE
ion	nding ath. r: Afte e fune	atloi	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Ir	njury M		k? Yes 2 □ No				
Division	or Attending after death. Diractor: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of in	ury - At home, fa	rm, street, fa	ctory, office		28f. Location (S City or Tox			ral Route Number,
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	To the Hospital or Atten within 24 hours after deat To the Funeral Diractor: completely filled in by the	edical	(Check only 2 X Medical Exam	ysician: To the best iner: On the basis of	f examination and	, death occu	rred at the tir ation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time.	cause(s) date and	and manner as	stated. to the cause(s)
	To the Ho within 24 To the Fu completel	Med	one) 29b. Signature and title of certifier	and manner st	ated.		29c. Licens				e signed (Month)	
	T. S. S.		255. Signature and title of certifier	Do all	10	un		C.M.E				2004
	/0		30. Name and address of person who c	completed cause of	leath (Itam 33a)	Tune Drine						
	•		20. Name and address of person who c	City ET	111	Penn §	treet,	Baltimo	ore, Mary	land	1 21201	
	Sta	te	31. Date filed (Month Day Year)	42 Regist	Signature	100	ald					
	Registr	ar	JUL & 0 2004			//						

State Registrar

11800383519 Baltimore, Maryland 21215-0036 3300PH 7/25/04 FILIPOVITS, RUBOLF

		For	•		artment of Health ar	nd Mental Hy	giene)						
		1 - State Registrament	11 PER FH G833	7/28	niticate of Death		Reg. No.	004	23724					
ysicia Medic		Decedent's Name (First, Middle, Last,	Lipevits			2. Date of De Month July	Day	Year 2004	3. Time of Death					
amin		4a. Facility Name (If not institution, give			4b. City, Town, or Location of	A .		County of Deet						
		HARFORD MEMORIA			111111	RACE		ARFOR						
eral ector		5. Social Security Number 6. Se 070-40-7648 Usual Residence of Decedent	x	Yrs.	Months Days Hours	Min. 8. Date of Bi (Month, D. April	5, 1	Co	hplace (State or Foreigr buntry) Hungary					
18		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits					
Tigg I	ţ	MD Cecil	C	onowi	nao				1 ☐ Yes 2 🛣 No					
rott	Funeral Director	10e. Street and Number		OHOWI	10f. Zip Code		10g. Citi	zen of What Co	lountry?					
100	O E	43 Campbell Cour	t		21918			United	States					
3	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	? (Specify Yes or N	D-	14. Race - Ame						
Examine	þ	Tion of the state	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No Specify:	dello nicali, etc.)		Black, White Specify:	White					
평	Completed	15. Decedent's Edu (Specify only highest grad	lication	16a. Dece	dent's Usual Occupation kind of work done during most o	f working	16b. Ki	nd of Business/	Industry					
Me	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)									
를		A. Cabada Nama (Can Middle Lank)	2	Gene	eral Manager				Catering					
• V	Be	17. Father's Name (First, Middle, Last) Paul Filipovits				Name (First, Middle		,						
natic	²			101 11 11		len Ivanko								
Iraun				19b. Mailir	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
6		COTT FILIDOVITE		10	4									
=		Scott Filipovits			4 Bentley Stree				787					
or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	ace of Dispo	osition (Name of matory or other place)	Date	20c. Lo	cation - City or	Town, State					
njury or oth	33	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State St.	ece of Dispo metery, crei Peter	osition (Name of matory or other place) TS Cemetery	Date 07/31/2004	20c. Lo	iberty,	Town, State New York					
any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State St.	Peter	osition (Name of matory or other place) S Cemetery 2. Name and Address of Facility	Date 07/31/2004 Ruck Tov	20c. Lo L ISON	iberty, Funeral	Yown, State New York Home, Inc.					
eny injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition 1 🕱 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licens	Removal from State St.	ace of Disponmentary, crem Peter 22	rs Cemetery 2. Name and Address of Facility 1050 York Road	Date 07/31/2004 Ruck Tov , Towson,	20c. Lo L /Son Mary	iberty, Funeral	New York Home, Inc 1204					
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it director, page 2 should be detached for use as the burial-transit up of use as the burial-t	Be Completed by Physician/Medical Examin	20a. Method of Disposition 1	20b. Phose St. St. St. St. St. St. St. St.	ence of): Do not ent ence of): ence of): ence of): ence of): ence of):	Desition (Name of matory or other place) TS Cemetery 2. Name and Address of Facility 1050 York Road Ler the mode of dying, such as can concern. Colory Description of the content of	Pate 07/31/2004 Ruck Tow Ruck Tow Towson, rdiac or respiratory a 23e. Did 1 24a. Was auto perfc 1 □ Yes Death (Check only only the perfc) 28d. Describe	20c. Lo L /SON Mary rrest, 2 obacco us Yes 2 obacco us Yes 2 obacco us An obacco u	Party or iberty, Funeral land 2 23d. Date of deliment to the land when the land land land land land land land land	New York New York Home, Inc. 1204 Approximate Interval Between Onset and Death onset and Death Year the cause of death? obably 4 Unknown topsy findings available completion of cause of 21 No					

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

25. Was case refer	red to medical	HARFOAD	MEUDEI	AL 24	26. Place of De	performed? 1 ☐ Yes 2 ☑ No eath (Check only one)	death? 1 ☐ Yes 2 🗱 No
examiner? 1 X Yes 2 □	No	11 11 1	ER/Outpatient		Othor	Home 5 Residence 6	Other (Specify)
27. Manner of Deat 1 XNatural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	28c	Injury at Work? 1 Yes 2 No	28d. Describe how injury of	occurred
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Special		t, factory, o	ffice	28f. Location (Street and N City or Town, State)	Number or Rural Route Number,
29a. Certifier (Check only one)	1☐ Certifying Ph 2☑ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death of ation and/or inve	occurred at stigation, in	the time, date and place my opinion, death occ	e, and due to the cause(s) an curred at the time, date and pl	nd manner as stated. ace, and due to the cause(s)

29b.	Signature	and	title	of ce	rtifier	
	(1)		1	/	1/	,
	1820		- 4		VZ . L	ŕ

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of Samuel July MA MA DAE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The same and address of person who completed cause of death (Item 23a) (Type, Print)

The same and address of person who completed cause of death (Item 23a) (Type, Print)

DO0 14206

AVE

BALDO Med

State Registrar

Medical C

BERNARD J. YUKNA
31. Date filed (Month, Day, Year)

JUL 2 8 2804

M))ME

32. Aggistrar's Signature

10

			1 _ State	State of Maryland / Depa	artment of Health and M <i>rtificate of Death</i>		000	and the second second
			Registrar 1. Decedent's Name (First, Middle, Last)		runcate of Death	2. Date of Death	J. No.	3. Time of Death
	Physici /Medio		Gladys Eliza			Jน้ำใั้ง 21	Day Year 2004	9:00 AM
	Examir	er	4a. Facility Name (If not institution, give str		4b. City, Town, or Location of Death		4c. County of Death	
			Manor Care- Rol 5. Social Security Number 6. Sex	and Park 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	O Data of Blat	N/A	
	Funeral Director			1. Age (111 yrs. last billiolay)	Months Days Hours Min.	8. Date of Birth (Month, Day, Y		place (State or Foreign
	ס		Usual Residence of Decedent			Aug. 12	2, 1911 M	aryland
	arylar show	_	10a. State 10b. County	10c. City, Town or Lo			1	0d. Inside City Limits
	Ba-f	ecto	Maryland N/A	Baltim				1 Yes 2 □ No
	th with the 23e or 2	ai Dire	10e. Street and Number 2315 Wineberry T	errace	10f. Zip Code 21209		g. Citizen of What Coul JSA	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygene. Importent: If item 27 Is marked other then "neturel", or Items 23e or 28e-f show important: If item 27 Is marked other then "neturel", or Items 23e or 28e-f show apply injury or other traumatic event, I'm Medical Examinar must be notified at once.	y Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
21215-0036	turel sel Ex	Completed by	15. Decedent's Educa	Year or Dates:	dent's Usual Occupation	16	ib. Kind of Business/In	
75	nin 72 n "ne	plet	(Specify only highest grade of Elementary/Secondary (0-12)	completed) (Give	kind of work done during most of worki DO NOT use retired)			of Mary-
212	d with giene ar the	Com	10th grade	College (1-4or 5+) Food	Service Worker		and Hospi	
	al Hy d other	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Ma	uden Sumame)	
Maryland	hould by Ment marked matic e	ဥ	William Morton 19a. Informant's Name/Relationship (Type	Print) 10h Mailie	Lucy ng Address (Street and Number or Rura	A Bouts Mumber 6	Since Town Charles Time	0-4-)
	ulth an 27 is r trau		Charles E. Grif					
re,	s 1 ar		20a. Method of Disposition	20b. Place of Dispo			c. Location - City or To	
E	Page nent o int: If		1 Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)		n Cemetery 7/2	7/2004	Woodlawn,	Maryland
altimore,	mit. partir porte y inju		21. Signature of Funeral Service Lensee	22	2. Name and Address of Facility Cha	atman-Ha	arris Fun	eral Home
<u> </u>	99 = 99		Juny Hours		240 Reisterstown			d 21215
П			23a. Parti. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do not ent cause on each line.	er the mode of dying, such as cardiac o	r respiratory arrest		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	are a	ofless	-of r	20 para	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	0			
h	#	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
	uted d ansit	Examin	Cause (Disease or injury that initiated events					
ó	ficate be executed physician and is the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):				
8760	ate be nysicia he bu	dicai	d					
9	artifica ing ph e as t	Med	IF FEMALE:					
Вох	death certifi e attending I id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delive Month	ry Day Year
	0 0 0	ysic	1 Yes 2 No 9 Unknown	4☐Pregnant at time of death 5☐ 9☐Unknown	Other (specify)		World	Day real
٦.	The law requires that the te has been signed by the bage 2 should be detached.		Part II. Other significent conditions contri	buting to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
ecords,	quires n sign ald be	d by	Arteriord	arolic Ca	Disorcula	1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
OS .	s been sign	oiete		Não	seone	24a. Was an	24b. Were autor	osy findings available
\mathbf{r}	The law cate has page 2 :	Completed				autopsy performed	prior to condeath?	npletion of cause of
Vital		BeC	25. Was case referred to medical examiner?		26. Place of Death	1 Yes 2 Check onl one	NO ILLIES	91140
01 <	Physicien: this certific ral director,	P P	1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		ne 5 🗆 Residenc	e 6 ☐Other (Specify)
ב	ding P. h. After t funera	on:	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how	injury occurred	
Sio	ttend death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	CO. Plans of lains. At home for	M 1 Yes 2 No	105 1 1 101		
Division	ial or Attendii s after death. al Director: A ad in by the fu	Certification:	4 Homicide determined	 Place of Injury - At home, farm, street building, etc. (Specify) 	eet, factory, office	City or Town, S	it and Number or Rural Itate)	Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death and 17 to the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier Check only 2 Medical Exeminar	ian: To the best of my knowledge, death :: On the basis of examination and/or inv	occurred at the time, date and place, a	nd due to the caus	e(s) and manner as sta	ated.
	To the H within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner stated.	2 License number			
)	F 3 F 8		Hound	13 (ola-	DZIG	80	Date signed (Month, I	104_
	2		30. Name and address of person who comp	pleted cause of death (Item 23a) (Type, I	Print) 1	63	1 -0	
	9		6717	Pouls He	agult 1	عب عب	- 5(2	215-
	Sta Registra		31. Date filed (Month, Day, Year) JUL 2 8 200	32. Registrar's Signature	Son K.			

			For State Registrar	State of	Maryland /		artment rtificate				lental H	ygiene Reg. No	m m =	1.	0076	2.0
	DI	No.	1. Decedent's Name (First, Middl				,				2. Date of D		5 U U	/oor	3. Time of Di	eath)
	Physici /Medic		Germ	gine (59/19	9 4	-				July	22 ^{Da}	2004	ear	2200	М
	Examir		4a. Fecility Name (If not institution	-					Location of	of Death		4c	County of	Death		
			Anne Arundel					napo					Anne			
п	Funeral		5. Social Security Number 061-14-7591	6. Sex 7.	. Age (In yrs. last I	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	av. Year)			place (State or F ntry)	oreign
	Director		Usual Residence of Decedent		88	115.					April_	24,1	916	Arge	entina	
	land ow		10a. State 10b. County		10c. City, To	wn or Lo	cation							1	0d. Inside City	Limits
	Mary -f sh	tor	MD Anne	Arunde1	Δnr	napo	1ie								1 X Yes 2	□No
	r 288	Director	10e. Street and Number		71111	паро	10f. Zip	Code				10g. Cit	izen of Wh	at Cour	ntry?	
	th with	al D	239 Anchorage	Court				214	01				USA			
	dear	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race -			
98	or Ite	F	1 Never Married 2 Mar	ried 1 ☐ Yes 2	XXNo		1⊡Yes 2				riican, etc.)		Specify:	White,		
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show dical Examinations be indiffed at	d by	3 Widowed 4 Divorced	Year or Date	es:											
7	"nat	Completed		nt's Education st grade completed)	16	(Giva	dent's Usual kind of worl DO NOT use	k done d	lurina mosi	t of work	ing	16b. K	ind of Busi	ness/ind	dustry	
12	within ene. than "	шć	Elementary/Secondary (0-12)	College (1-4			naker	o rourou,	,) II			
9	filed with Hygiene. other than		17. Father's Name (First, Middle,			TOME	nakei		18. Mothe	r's Name	e (First, Middle		Own H			
an	d be ental ked c	To Be	William Morris	on Miller												
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygtene. I Health and Mental Hygtene. Item 27 is marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural" is 1 and 1	-	19a. Informant's Name/Relations		19	9b. Mailir	ng Address	(Street a			salie al Route Numi			ate. Zip	Code)	
	and 2 saith a n 27 is		Edward S. Gall	agher (Husl							Annapo					
Baltimore,	of Health of Health fitem 27		20a. Method of Disposition		20b. Place	of Dispo	sition (Nam	e of	- 1		Date		cation - C			
Ë	⊕ o = =		1 ☐ Burial 2 X Cremation 1 ☐ Donation 5 ☐ Other (S		ate		emator			-27-	2004	Po.14	imor	0 1	√D.	
a E	그 든 걸 날		21. Signature of Funeral Service		IICCIC		. Name and	Addres	s of Facilit	v			TIHOT	e, r	Ш	
ä	Depar Depar Impor any ir		110 A. C	- Arm		1	Harde	sty	Fune	ral	Home, , Anna	P.A.	. MD	21/	.01	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	used the death. Do	o not ent							2 9 1112		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	only one oddso on odd	_			E.							Onset and Dea	
	-/Medical-		resulting in death)	a Due to (of	as a consequenc		76~/	•						- 6	one we	: </td
	Examiner		Sequentially list conditions	b												
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequenc	e of):										
	and tran	Examine	that initiated events resulting in death) Last	c. Due to /or	as a consequenc	0.06):										
8760,	be executed sician and burial-transit			500 10 (01	as a consequenc	a 01).										
687	ate he	Physiclan/Medical		d				_								
	death certific attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy								23d. Date	of delive		
Вох	death atter	iclar	in the past 12 months?		h 2 ☐ Fetal dea nt at time of death		Ectopic pre Other (spe						Month		Day Yea	r
0	at the de by the a tached	hysi	9 Unknown	9□ Unknow	'n		``									
σ,	es that igned to be det	by P	Part II. Other significant condition	ons contributing to dear	th but not resulting	in the u	nderlying ca	use give	n in Part I.		23e. Did	tobacco u	se contrib	ute to th	e cause of deat	h?
of Vital Records,	w require been sig should b										10	Yes 2	□No 3	☐ Proba	ably 4 Tunk	nown
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Ħ	ician: Th certificate rector, pag	Be C	25. Was case referred to medica examiner?		_				26. Place	of Death	Check onl					
<u>_</u>	S S	2	1 Yes 2 No	Hospital:	patient 2 ER/C	Dutpatier	t 3 DO	Othe	r: 4 □ Nu	rsing Hor	ne 5 ☐ Res	idence	3 □Other	(Specify	')	
	ding Ph h. After th funeral	:uo	27. Manner of Death 1 ⊟Natural 5 □ Pendir	28a. Date of (Month,	Injury 28b Day Year)	. Time of Injury	28	c. Injury Work	at ?	4	28d. Describe	how injur	y occurred			
Sio	Attending r death. ector: After by the funer	catl	2 Accident investi	gation			М	1 🗆 Y	'es 2 □ 1	No _						
Division	I or Attendate after death Director:	Certification:	4 Homicide determ	sined 288. Place of	f Injury - At home, , etc. (Specify)	farm, str	eet, factory,	office		:	28f. Location (City or To			or Rural	Route Number	,
	spital or ours afte neral Dir filled in		CO. C. C. C. C. C. C. C. C. C. C. C. C. C.	- 51												
	Hos 24 ho Fun stely f	edical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basi and manner	is of examination a	ge, death and/or in	occurred a restigation, i	t the timing the street that the street in the street that the street that the street the street in the street the street that	e, date and inion, deat	d place, a th occurr	and due to the ed at the time,	cause(s) date and	and mann place, and	er as sta due to	ated. the cause(s)	
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Mec	29b. Signature and title of certifie	1 1	1 /		29c.	License	number			29d. Dat	e signed (/	Month, L	Day, Year)	
	- s - ō		> h/(a dt)	-Wal	K		1	D5	181	19		Ti	1-	24	1 20	04
	Di		30. Name and address of person	who completed cause	of death (Item 23a) (Type	Print)					7)	-)		//	
	\		132 Holidas			01	AV	7	polis	M	0 1	Nat	thev	7.	malta	4
	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	0	**1		•	-		-			•	-
	Registr	ar	JUL 2 8 200	14 Beneux	B. B.		1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #6 PER FH G833 762846Cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a, Facility Name (If not 4b. City, Town, or Location of Death Examiner Institution, give street and number, 4c. County of De 5. Social Security Number Age (In yrs. last birthday) **Funeral** . 2**XX** -88 Director -10 7-3-16 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show other traumetic event, the Medical Examiner aust be notified at 1 ☐ Yes 2 No Director 28e-f 10e, Street 10g, Citizen of What Country? or Items 23a death by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. filed within 72 hours after of Hygiene.
Hygiene. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary College (1-4or 5+) LABOVER 1 and 2 should be filed with and Mental Hygien em 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be ပ Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of **M**Burial 2 ☐ Cremation 3 ☐ Re oval from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 23a. Parl1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. of dying, such as cardiac or respirate Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician 20V /Medical Due to (or as/a Examiner O Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE P.O. Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Other: 1 🗌 Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 X esidence 6 Other (Specify) this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of scribe how injury occurred 28d. D After Certification: Injury Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation Accident Accide 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2004

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32. Registrar's Sighature

29d. Date signed (Month, Day, Year)

			For State Registrer	State of Marylan		ment of Hea icate of De		ital Hygier	2001.	23728
	Physici /Medic		1. Decedent's Name (First, Middle, La.	st)	Frah	am	2.	Date of Death Month	S accord	3. Time of Death 1 10:22 M
	Examin Funeral Director		113.74.820	dical Co	WHA last birthday) If		nore	Date of Birth Wonth Day, Yes	tc. County of Deal	hplace (State or Foreign
	aryland ehow	2	Usual Residence of Decedent 10a, State 10b. County	10c. Cit	y, Town or Location					10d. Inside City Limits 1 ¥Yes 2 □ No
	vith the M or 28e-f	Directo	10e. Street and Number	Timore St		Of. Zip Code	1205	10g. (Citizen of What Co	ountry?
980	iges 1 and 2 should be tiled within 72 hours etter death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23s or 28e-f ehow or other freumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Ye	. /	nic Origin? (Specify fexican, Puerto Rica pecify:	Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify: BU	
21215-0036	nin 72 hou in *natura Medical I	Completed	15. Decedent's E. (Specify only highest gra	Jucation de completed) College (1-4or 5+)	(Give kind life. DO	's Usual Occupation of work done during NOT use retired)			Kind of Business	Industry
	be tiled with tal Hygiene. d other than event, the h	Be	17. Father's Name (First, Middle, Last,	as Hans	UNG	emplor 18.	Mother's Name (Fi		JNEMPL en Sumame), PRAHA	n n
Maryland	2 should be and Mental is marked c	안	19a. Informant's Nam — elationship (1	1 1	ddress (Street and	Number or Rural Ro	Δ		Zip Code)
	of Health of Health fitem 27 r other tr		20a. Method of Disposition 1 Description 3	1 0	Place of Disposition	in (Name of any or other place)	Date Date	20c.	Location - City or	Town, State
Baltimore	permit. Pages Department of Importent: If it any injury or o		4 Donation 5 Other (Special 21. Signature of Funeral Service Lices	v) M+	: LION () 22. No 491	EMETER) ame and Address of TORK	Facility VIV	HNCE	LTUMPLE, REENE RE, MARY	MARYLAND UNEXAL ATMAC LAND 21212
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or common shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	plications that caused the death one cause on each line. a. Authorized to for as a consequence of the conse	uuocav juensalof):	ne mode of dying, si	uch as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
3760,	ate be executed hysician and he burial-transit	Ical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):					
.O. Box 68	v requires thet the death certiticate be ex been signed by the attending physician should be detached for use as the butia	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	il death 3 ⊟Eci	opic pregnancy her (specify)			23d. Date of de Month	ivery Day Year
Ω.	signed b	d by Pt	Part II. Other significant conditions of	contributing to death but not res	sulting in the unde	riying cause given in	Part I.	23e. Did tobacc	- 10	o the cause of death?
I Records,	The law requir ate has been si page 2 should l	complete	Chiere Re	nal Fail	me			24a. Was an autopsy performed'	? death?	utopsy findings available completion of cause of
f Vital	ding Physician: The lav h. Atter this certiticate has funeral director, page 2	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ To	Hospital: 1 Inpatient 2	ER/Outpatient	Other	3. Place of Death (C		6 □Other (Spe	cify)
ion of	Attanding Phr r death. ector: Atter th by the funeral	atlon:	27. Manner of Death 1 Anatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes	28d 2	. Describe how in	ijury occurred	
Division	To the Hospital or Attandii within 24 hours after death. To tha Funeret Director: A completely tilled in by the fu	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, fy)	factory, office	28f.	Location (Street City or Town, St	and Number or R ate)	ural Route Number,
	ne Hospit 124 hours na Funere sletely tille	edical (nysician: To the best of my knominer: On the basis of examination and manner stated.						
	To th within To th comp	Me	29b. Signature and title of certifier	Want	(10)	29c. License nu	amber	29d. I	Date signed (Mon.	h, Day, Year)
	1		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Prir	1) DY O	147	1 St.	Paul.	Place
	St	ate	31. Date filed (Month, Oay, Year)	32. Registrar's Signa	YLOU (A	1 Ceus	Her -	Ba Hyw	uso, au) 21à02
	Regist		JUL 2 8	2004 Dener	جر س	Love	2			

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Amend items 23a 25 27 28a-f per meo 8837 11-9-04 vt

State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1200 P M 2004 26 Ju14 /Medical 4a. Facility Name (If not institution, give street and number)
5+. Aanes Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Agnes Balhmore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 17 M 2□ F 113-36-0407 Usual Residence of Decedent Yrs. Director 6,19 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director Maryland more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö Itеms 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ith and Mental Hygier 27 is marked other the r traumatic event, Ibs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ 19a. Informant's Name/Relationship (Type, Print) (W 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heatth ar Important: If item 27 is any injury or other trau once. Glenn 0 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) tiona 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Balto. Ma W. North Ave. 23a. Pari1. Enter the cirease, or complications that caus shock, or heart future. List only one cause on each death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each Immedia e Cause (Final disease or condition resulting in death) Acute subdural benatoma with complications **Physician** Two weels /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) CALEXAMINER Box 68760, CERTIFICATION APPROVED BY NED Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic preonancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown signed by م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1XYes 212 No 1 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Division 1 Pivatural 5 Pending death. 1 Yes 2 No 2 Accident 3 ☐ Suicide i Director: / investigation 7-8-04 subject fell unk 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours after To the Funeral Dire home 1233 N Augusta Ave. Balto. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and/title of certifier 29c. License number 29d. Date signed (Month, Day, Year) growly MD P17008 July 26,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21229 Sulwia Karpinski 900 Caton Ave 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 2 8 2004 Registrar

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MELVIN

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			1 - State of I		artment of Health and	d Mental Hygie	0 0 0 1
	Q		Decedent's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·	2. Date of Death	3. Time of Death
	Physici /Medi		Charles Holla	rud		Month 07	Day Yeer 7:56 PM
	Examir		4a. Facility Name (If not institution, give street and numb	ər)	4b. City, Town, or Location of De	eath	4c. County of Death
			University Hospital		Baltimore		N/A
	Funeral Director		5. Social Security Number 6. Sex 7. 217 - 40 - 9706	Age (In yrs. last birthday, Yrs.		in. (Month, Day, Ye	9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent	58 ^{frs.}		Apr. 25,1	946 Maryland
	nylan thow	_	10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits
	Ba-f s	Director	Maryland N/A	Bali	timore		1 TYYes 2 □ No
	be filed within 72 hours after death with the Maryland hal Hygiene. od other than "natural", or Items 23a or 28a-1 show event, the Modical Exatt act must be redified at	Dire	401 E. 25th Street Ap	t.12J	10f. Zip Code 21218	10g.	Citizen of What Country?
	ns 23	Funerai	11. Marital Status 12. Was Decede		Was Decedent of Hispanic Origin?	(Specify Yes or No-	USA 14. Race - American Indian,
9	after or liter	Fun	Unk 1 □ Never Married 2 □ Married 1 □ Yes 24 If Yes, Give	s? ∃No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White, etc.
203	ural',	d by	3 Widowed 4 Divorced Year or Date	5:	1 Yes 2 No Specify:		Specify: Black
15-	n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation s kind of work done during most of a DO NOT use retired)	vorking 16b	. Kind of Business/Industry
12	within than than	дшс	Elementary/Secondary (0-12) College (1-4d)r 5+)			
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/lar	2 should be and Mental Is marked c	To B	John Holland		Virgin	nia Boogs	
Maryland 21215-0036	2 sho and Is m		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or	Rural Route Number, Ci	ty or Town, State, Zip Code) Maryland 21207
e, <u>r</u>	1 and Health em 27 ther tr	1	Virginia Billy-SteWa	1221			
mor	Pages nent of l int: If its iry or o		1 Burial 2 Cremation 3 Removal from Sta	te Holly H	osition (Name of matory or other place) ill Memorial	$\operatorname{Gar}^{200}_{\bullet}$. Location - City or Town, State Ssex, Maryland
Baltimore,	permit. Pages 1 a Department of He important: If item any injury or oth		21. Signature of Funeral Service Livensee	5	2. Name and Address of Facility C	hatman-Haj	ris Funeral lome timore, Md 21215
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not en	ter the mode of dying, such as card	iac or respiratory arrest,	Approximate
	- Pnysician		Immediate Cause (Final disease or condition	tate canc			Interval Between Onset and Death
	/Medical		resulting in death)	as a consequence of):	er, Mutastatic		
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	ed sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence ofly			
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8760,	cate be executed physician and the buriat-transit	dical E	d				
68		Medi					
Вох	death certifica attending ph for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth		Ectopic pregnancy		23d. Date of delivery
0.	The law requires that the death certifin the has been signed by the attending page 2 should be detached for use as	Physician/Me		at time of death 5	Other (specify)		Month Day Year
σ.	res that the de signed by the a be detached t	y Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Vital Records,	quires n sign	ed by	Lung adenocarcinon			1 ☐ Yes	
000	aw requir s been si 2 should	piete	J			24a. Was an	24b. Were autopsy findings available
R	The lay	Completed				autopsy performed	prior to completion of cause of death?
ita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?		26. Place of D	1 ☐ Yes 2 🗶 I eath (Check only one)	40 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
<u></u>		2	1 ☐ Yes 2 No Hospital: 1 Inpa	The second secon		Home 5 Residence	6 ☐Other (Specify)
ou c	ting F	lon:	27. Manner of Death 1 XNatural 5 ☐ Pending 28a. Date of In (Month, L	jury 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
Division of	Attendideath ctor: A	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of I	28f Location (Street	and Number or Rural Route Number,		
Ö	al or A s after Il Dire	Certification:	4 Homicide determined 289. Place of the building,	njury - At home, farm, stre etc. (Specity)	eet, factory, office	City or Town, Sta	ate)
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai C	29a. Certifier (Check only one) Check only one) Certifying Physician: To the besis and manner.		n occurred at the time, date and place vestigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
	To th within To the compl	Me	29b. Signature and title of certifier	00	29c. License number	29d. C	Date signed (Month, Day, Year)
•			Meghan //	When, M	D AU417643	5 15237	1/17/04
j	2		30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	14 3/21	71,10
	Sta	to	31. Date filed Month, Day, Year) 32. Regis	trans Signature	UNIV. 34 1	VID MEd	Center
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death **Physician** gans 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death NIA Maryland Social Security Number 5. Social Security Number 214-50-5948
Usual Residence of Decedent 9. Birthplace (State or Foreign Country) **Funeral** Days 10M 2□F Hours Min Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at Completed by Funeral Director MD Baltimore 1 Fres 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: Specify: Black 3 Widowed 4 Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Hagans Prov 19a. Informant's Name/Re ationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, Department of Health a Important: If item 27 Is any injury or other tra Paula Hagans - Sister Hollin MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest V.A. `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fur ral Service Licensee 22. Name and Address of Facility 21229 Gary P. March F/H 270 Fred Pass Balto, ms 23a. Part I little the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Diration Due to or as a consequence of): /Medical **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 🗆 No 3 Probably 4 Dishknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? (es 2 4 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 1 🗌 Yes Other: 2 (No 1 Thipatient this 2 ER/Outpatrent 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

(Check only one)

29b. Signature and tite of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0/0 32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Monti 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore (Jecours If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 64-083 1 ☐ M 2 🔭 P Director Yrs. November, 3, 1954 Maryland Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exampler must be notified at 10d, Inside City Limits Baltimore NIA 1 Yes 2 □ No Director MP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 2708 Ave USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ☐ Widowed 4 Doivorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "any injury or other traumatic event, Item any injury or other traumatic event, Item any injury. Elementary/Secondary (0-12) College (1-4or 5+) 11th Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kane David DUB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John 2708 2708 Kiggs 20b. Place of Disposition (Name of Hendrix 21216 MD 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State mt. Zion Cemetery * 4 ☐ Donation / 3 ☐ Other (Specify) 21. Signature Vineral price 22. Name and Address of Facility It 270 Freshillon Pass Balto, mo 21229 23a. Party Enterthis disease, or complications that caused the death, shock, or heart failure. List only one cause of ach line. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Examiner 30 mars Sequentially list conditions, in a please of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transit Due to (or as a consequence of). physician Box 68760 Physician/Medical as the attending IF FEMALE: nse : 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à signed t 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by CANCENCE MALL TOS ausno 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death?

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[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of conifier 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Da 32. Registr r's Signature Registrar

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			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	lilicate of t	Jean	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia		ALVINA HAGE	RTY HELLMANN				Month		8:15A M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of	
			3900 North Charles	s Street		Baltim				/A
	Funeral Director		5. Social Security Number 6. Sex 215–24–8333	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day January	v, Year)	. Birthplace (State or Foreign Country) Pennsylvania
	and W		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
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p	al Hy	Be (17. Father's Name (First, Middle, Last)	Haganty					Maiden Sumame) na Baumai	2
yla	ould to	T _o	Frederick Alfred		400 14 18					
Mar	12 sh h and 7 Is n traun		Joan Greenberg		1				or, City or Town, St	lorida 33952
ē,	1 and Healt tem 2		20a. Method of Disposition	20b. Pl	lace of Dispo	sition (Name of		Date	20c. Location - Ci	
ē	Pages ent of nt; If it		XIX Burial 2 ☐ Cremation 3 ☐ R A ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other place dge Cemet	ery 7/28,	/04	Pikesvil	le, Maryland
Baltimore, Maryland 21215-0036	permit. I Departm Importar any inju		2) Fignature of Funeral Service Licens				ss of Facility Mit	chell-Wied	defeld Fune	ral Home Inc. ryland 21212
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	n. Do not ente	er the mode of dyin				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(Mgel)	Luis 1	heard -	Larjuno			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	0/				
ŀ	LAdilillei	<u>_</u>	Sequentially list conditions,	Due to (or as a consequ	(e(C.)	mjaro	Fun			
	rted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Das to for de a somoods	301100 01).					110
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
8760,	cate be executed physician and the burial-transit	dical		1.						
9	artifica ing ph e as th	Med	IF FEMALE:							Maria
Вох	death certific e attending p ed for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy	,		23d. Date of Month	,
0	0 0 0	Physician/Me	1 Tes 2 No 9 Unknown	4□Pregnant at time of de 9□Unknown	eaun o	Other (specify)				
Д	that the	by Ph	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
Records,	w requires been sign should be							1 □ Y	res 2 No 3	☐ Probably 4 ☐ Unknown
900	aw as b	Completed						24a. Was autop	an 24b. We	re autopsy findings available or to completion of cause of ath?
H.	Th ate pag	Com						perfor		ath?]Yes 2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or	th (Check only o		
of	Phys this al dii	. To	1 ☐ Yes 2 ☑ No ☐ 7. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		4 🔲 Nursing H	ome 5 Resid	dence 6 Other	
on	ding th. After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No			
Division	l or Attanding after death. Diractor: Afte I in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
_	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical C	29a. Certifier (Check only one)	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death tion and/or in	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occu	, and due to the orred at the time, o	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	To thi Within To the	Me	29b. Signature and title of certifier	01		29c. Licens	e number	- 1	29d. Date signed (Month, Day, Year)
	7		I aw A	Letu		Ĩ	12244	18	7/26/04	,
	10		30. Name and address of person who co							
			Paul A Gertler	MD 3900 North Ch	narles S	treet Suite	e 104 Balti	more, Mary	land 21218	
	Sta Regist		31. Date filed (Month, Day, Year) JUL 2 8 20	32. Rygistrar's Signa	A S	Spork				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 7:30 p Helen Moler Huber July 26. 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Stella Maris I 1MOFILUM

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | (Month, Day, Year) | Feb. 11,1926 Timonium 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 20 F 78 234-38-9846 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Perry Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 USA 4-H Dunsinane Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Marned Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Marketing Specialist State Of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian DeLancev Moler Holland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If itam 27 is: Cynthia H. Spath / Daughter 1424 Redfield Road Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State ortant: If it 4 Donation 5 Other (Specify) 7/29/04 Zames Luth.Cem. Uvilla West Virginia 21. Signature of Euperal Service Lizense 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md.21204 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caus to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached? Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s 1 Yes 2 X No certificate Vital director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide filled within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUI 2 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day **Physician** 23, Doris M. Horn 2004 July 7:55 pm /Medical 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Mariner Health of Overlea Baltimore If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🖫 F Days Months Director 212-26-0441 76 March 10,1928 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f ehow any Injury or other treumatic event, If the Medical Exercines man be inclined at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6116 Belair Road 21206 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by It Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Plant Worker BG&E 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Horn Marie Eder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5900 Grace Avenue Baltimore, Maryland 21206 Joseph Fiedler- Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balt/Wash. Crematory 7/27/04 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore, Maryland 21206 20 23a. Par 1. Inter the disease or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed attending physician and f for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as e consequence of) resulting in death) Last certificate has been signed by the siftector, page 2 should be deteched Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? Toyes 2□ No 3 Probably 4 Unknown \$ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No ۵ 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manper of Death Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital of within 24 hours a To the Funerel Completely filled 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) Bultinore

Registrar

State

31. Date filed (Month, Day, Year)

2 8 2004

32. Registrar's Signature

DHMH 16 Rev 6/95

			1 - For State Registrar	State of	Maryland		artment rtificate				lental H		ene	*	237	39
	Physici	an	1. Decedent's Name (First, Middle, L	ast)							2. Date of Month		Day	Yeer	3. Time o	f Death
	/Medic		Gretchel A. Hal								July	23,	2004		7:56	a. ^M
7	Examir	ner	4a. Facility Name (If not institution, g	ive street and num	ber)		4b. City,	Town, or	Location	of Death			4c. County o			
			2903 Ross Avenu	e				jeme1	ce If Under	O.4 Lista			Baltim			
п	Funeral			Sex 1 M SEXF	'. Age (In yrs. la 68	Yrs.	Months	Days	Hours	Min.	8. Date of (Month, June	Day, Y	ear)	Coun		
	Director		213-34-0334 Usual Residence of Decedent	2121							June	<u> </u>	1936		ginia	
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside C	ity Limits
	Many Fish	ţŏ	Maryland Balti	more	E	dgemer	re l								1 🗆 Yes	2 No
	r 288	irec	10e. Street and Number	MOLO_		wg 011101	10f. Zip	Code				10g	. Citizen of W	nat Cour	try?	
	h with	a D	2903 Ross Avenu	e			21	L219				Ţ	Jnited	Stat	es	
	deat	ner	11. Marital Status	12. Was Deced		S. 13. \	Was Deced	ent of Hi	spanic Ori	igin? (Spe	ecify Yes or Rican, etc.)	No-		- Americ	an Indian,	
9	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show he Medical Examinat must be notified at	by Funeral Director	1 Never Married 2 Married		2 🔂 No		1 Yes 2		Specify:		1 110411, 010.7		Specify:			
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CA	Hygie ther		17. Father's Name (First, Middle, La.	+4 st)		ACCOL	ıntant	- Pay			(First, Mid	dle Ma	iden Sumame			
an	d be ental ced o	o Be	Armon Walton	,							Baugh			,		
Maryland	12 should be filed within "h and Mental Hygiene." I's marked other than "reumatic event, the Me.	To	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	na Address	(Street a					City or Town, S	tate. Zin	Code)	
Ma	od 2 s lith ar 27 ls		Victoria A. Cies		iece)		Ross		,				aryland			
ē,	iges 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hyglene. If item 27 is marked other than "naturel", or items 23a or 28a-f show or other treumatic event. It is Medical Examinational Lancillisa at or other treumatic event.		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Nam	ne of			Date		c. Location - C			
no	ages ant of it: If i		1 ⊠ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec		late	metery, cren Lawn				/27/	2004	Ba	altimor	e. N	larvl a	nd
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tre <u>900cs</u> .		21. Signal re of F ral Service Lic		/ Ogh	22	Name and	d Addres	s of Facilit	hv						
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	/Medical		disease or condition resulting in death)		or as a consequ		7	(60							MIMS	
	Examiner		Promotion that are differen	, Athe	psule	inter	Cur	lion	juso	010	- ni	500	e SC		10 41	5
F	D =	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a consequ	ience of):										
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87	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d							_			-		
9 ×	leath certifica attending pl	/Me	IF FEMALE:	23c. If yes, outo	ome of pregnar	nev										
Вох	atten for u	lan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 15 No	1 Live bir	th 2 Fetal	death 3	Ectopic pre						23d. Date Mont		_	Year
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<u>α</u>	uires that the signed by the detaction	y Pt	Part II. Other significant conditions	contributing to de	ath but not resu	ılting in the uı	nderlying ca	ause give	n in Part I		23e. D	id tobac	cco use contrib	oute to th	e cause of	death?
Records,	quire; n sign	Q D	Diabetes M	ellitu	>						1	☐ Yes	2 □ No 3	□ Prob	ably 4	Unknown
00	w requires been si should?	lete									24a. W		24b. W	ere autor	osy findings	available
Re	ilcien: The lav certificate has rector, page 2	Completed by									ai	itopsy erforme s 20	d2 de	ath?		ause of
tai	en: T	Be C	25. Was case referred to medical						26 Place	of Death	1 Te		NO IL	Yes	2LI NO	
>	Physicien: this certific ral director,	0	examiner? 1 ☐ Yes 2 No	Hospital:	patient 2 🗆 E	ER/Outpatien	it 3□ DO	A Othe		irsing Ho	1. 10		e 6 Other	(Specify	1	
10		T iii	27. Manner of Death	28a. Date of (Month)		28b. Time of		8c. Injury	at	_	- '		injury occurre		/	
ion	Mtending death. ctor: Aft y the fun	atlo	1 Natural 5 Pending 2 Accident investigat		i, Day rear)	Injury	М	Work	r ∕es 2□	No						
Division of Vital	Atte	ific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place	of Injury - Al hor g, etc. (Specify	me, farm, str	eet, factory.	, office			28f. Locatio	n (Stree Town, S	at and Number	or Rura	Route Nun	nber,
D	s after s afte	Certification;														
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	edical	29a. Certifier 1 Certifying I	Physician: To the aminer: On the ba	best of my knov	wiedge, death	occurred a	at the tim	e, date an pinion, dea	d place,	and due to t ed at the tin	he caus	se(s) and man	ner as st	ated. the cause(s	3)
	the hin 2 the f	Med	one)	and mann	er stated.				number							
	To You	-	29b. Signature and title of certifier	1				. License) 39				230	. Date signed	(WOHEH, I	vay, rear)	
	40.	10	Junu 1	W	-4-4	00-1-7		ר כ ע	ر کر کر			70	M 54	1 2	-009	
	įΰ		30. Name and address of person wh	completed cause	or death (Item	23a) (Type,	Print)	$-\Omega$	1. 1	2011	rimo	19	LAAD	21	219	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	gis ar's Signat	ure	0 00	170	~ · V	74.	11000	· C	(000.)			
	Regist		JUL 28	2004	Deneva	J. J.	1	20	21							

			1 - State of Mary	•	artment of Hartificate of L			ene J. No. O O I.	2371.0
	Physici	an	Decedent's Name (First, Middle, Last) Jane Cardullo Ingaglio				2. Date of Death July 24,	Day 04 Yea	3. Time of Death 8:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deal		4c. County of De	
ı	LXaiiiii	CI	420 Nollmeyer Road		Bowley	's Quar	ters	Balti	more
	Funeral Director			yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country) ASPINGTON
	pu 🛦 🗀		Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or Lo	ncation				10d. Inside City Limits
	Maryla f sho	or	Maryland Baltimore	•	y's Quarte	ers			1 Tyes 2 No
	28a-	rect	10e. Street and Number		10f. Zip Code		100	g. Citizen of What	
	h with	ID IE	420 Nollmeyer Road		21220	0		United S	States
	be filed within 72 hours after death with the Maryland al Hygiene. Hygiene de other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event. The Medical Examiner must be mullied at	by Funeral Director	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of His	spanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc.
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify: W	nite
2-0036	2 hou		15. Decedent's Education	16a. Dece	dent's Usual Occupa	ition	16	6b. Kind of Busine	
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Maryland 21		Be	17. Father's Name (First, Middle, Last)				me (First, Middle, Ma	,	
<u> </u>	should be nd Mental marked o	2	John Boss 19a. Informant's Name/Relationship (Type, Print)	10b Mailir	an Address (Street a		rice Carto ural Route Number, (- Zin Code)
<u>8</u>	2 2 2 2		Diana Mitchell/Granddaughter		-		timore, Ma	-	
อ์	tem 27		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	1 -		c. Location - City	
altimore,	Pages ent of nt: If i		1 Marial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	t. Joseph	natory or other place Cemetery	7/28	/2004 Woo	olwich Tv	wnshp,NewJers
Balti	permit. Pages Department of t Important: If its any injury or of once.		21. Sign turn production and Service Licensea	~ In	2. Name and Addres	Tuneral	Home of D	undalk, 1	Inc.
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dying	lvenue g, such as cardia	Dundalk, N c or respiratory arres	daryland t	Approximate Interval Between
. =	Physician	i ii		WALL (E11 1	HAIR	CANCE	R	Onset and Death
	/Medical		resulting in death) Due to (or as a co	onsequence of):		vive	CHIOCE		e morrins
	Examiner	L	Sequentially list conditions, b. Use to for as a condition of the conditions of the	al an artist of the last of the					
١.	ted	nlne	cause. Enter Underlying Cause (Disease or injury	и инакритенного стр.					
,	execu n and ial-tra	Examiner	that initiated events c	onsequence of):					
8760	cate be executed physician and the burial-transit	dlcall	d						
9		Φ	IF FEMALE.					1	
ROX	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23c. If yes, outcome of pregnant in the past 12 months? 1□ Live birth 2□	Fetal death 3	Ectopic pregnancy			23d. Date of o	elivery Day Year
o.	at the dea by the al	/sici	1 ☐ Yes 2 🕅 No 9 ☐ Unknown 9 ☐ Unknown	e of death 5	Other (specify)			WORL	Day 16ai
7	res that the igned by be detact		Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute	to the cause of death?
g. D.	quires an sign uld be	d by	CHRONIC OBSTRUCT				1X Yes	2 No 3	Probably 4 Unknown
ecords,	s been should	Completed	SEVERE PROTEIN CALO				24a. Was an	24b. Were	autopsy findings available
Y	sician: The law certificate has b irector, page 2 s	omp	7.25. 27. 27.20		11001	111101	performe	d? prior to	o completion of cause of
Vital		O	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 ☐ ath (Check only one)	No 1 □ Ye	- INU
ot <	Physic this ce al direc	To B	examiner? 1 ☐ Yes 2 🕱 No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Othe	r. 4 ☐ Nursing H	Home 5 🔀 Residence	ce 6 □ Other (Sp	pecify)
<u>د</u>	ding Ph h. After th funeral	on:	27. Manner of Death 28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Work	.?	28d. Describe how	injury occurred	
<u>s</u>	ttendi death tor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	At home form the		fes 2□No	206 Leasting (Ctra	at and Number or	Describ Basela Missaba
DIVISION	after death after death Director: , d in by the f	Certification;	4 Homicide determined 28e. Place of Injury building, etc. (5	Specify)	eet, ractory, office		City or Town,	State)	Rural Route Number,
	Hospite 4 hours Funeral ely fillec	edical C	29a. Certifier (Check only one) 127 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of example and manner stated	amination and/or in	n occurred at the tim- vestigation, in my op	e, date and place inion, death occi	, and due to the cau urred at the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier		29c. License	number	29d	. Date signed (Mo	nth, Day, Year)
	- ≤ - ŏ		Ampere Lin	exip	D4:	2986		7/24/0	04
	3		30. Name and address of person who completed cause of death	(Item)23a) (Type,	Print)			1-11	
	9		JOYCE E. KING, M.D. 9101	FRANKL	IN SQUA	RE DR	#205 BA	LTIMOR	EHD Z1237
	Sta		31. Date filed (Month, Day, Year) - 32. Registrer's	Signature	7				

		•	_ FOI	partment of Health and Men	ntal Hygier	
			Decedent's Name (First, Middle, Last)		Date of Death	3. Time of Death
	Physicia /Medic		CLARENCE J. JOHNSON		Month 26	Day 2004 12 19 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			MERCY HOSPICE	BALTIMORE		N/A
П	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	Date of Birth (Month, Day, Yea	
	Director		218-12-0210 80 YIS. Usual Residence of Decedent	MA	AR 2 192	4 MARYLAND
	yland		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	e-1 st	ctor	MARYLAND N/A BALTI	MORE .		XXYes 2 □No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath w		1418 N ELLWOOD AVE	21213		U.S.A.
	er de Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 □ Never Married XXX Married XXX es 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes XXNo Specify:		Specify: BLACK
ğ	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show the Musical Exertified in the state of the confilted at	ted		edent's Usual Occupation	16b	. Kind of Business/Industry
215	thin 7 e. an "n	ed d	(Specify only highest grade completed) (Giv. Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)		
2	ed wil	Completed		STEEL WORKER		ETH STEEL
n	be fill d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fi	irst, Middle, Maid	len Sumame)
Maryland 21215-0036	should be filed vind Mental Hygies marked other tumatic event, In	은	CLARENCE DISTANCE	GERALDINE		
⊒ Z	d 2 sho th and 7 is mu treum			ling Address (Street and Number or Rural Ro		
	1 and Health tem 27	1 3	20a Method of Disposition 20b. Place of Disp	B N. Ellwood Ave. Ba		Cocation - City or Town, State
<u>o</u>	Pages nent of int: If it		1 2 Burial 2 Cremation 3 Hemoval from State	ematory or other place)	0.4	
Baltimore,		l- i	21. Signature Sineral Service Licensee	LLE VETERANS 07-29- 22. Name and Address of Facility		OWNSVILLE, MARYLAND
m	permit. Departr Importr any inj			VILLIAM C BROWN COMMU 206 W NORTH AVENUE	JNITY FU	NERAL HOME P.A.
			23. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		spiratory arrest,	Approximate Interval Between
	Priysician	ne de	Immediate Cause (Final disease or condition	al sutintedo	e dis	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		-	
	LAGITITICI	Ļ	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	ted	Examiner	Cause (Disease or Injury			
	execunand and al-tra	Exar	that initiated events c			
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		d			
9	ntifica ng ph as th	Physician/Medical	IF TENALE.			
Вох	eath certific attending pl	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day Year
С П	the a	/slci	1	Other (specify)		Monat Suy Tour
P. 0.	that the death led by the atter detached for u		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
ds,	w requires that been signed to should be det	d by	asbestosis		1 Yes	2 No 3 Probably 4 Unknown
COL	w req been shou	Completed	orland fixasis		24a. Was an	24b. Were autopsy findings available
Be	he lav e has age 2	d E	1170313		autopsy performed	prior to completion of cause of death?
ta	ucien: The certificate rector, pag	O	25. Was case referred to medical	26. Place of Death (Cl	1 Yes 2	No 1 Yes 2 No
<u>=</u>	Attending Physicien: r death. ector: After this certifics by the funeral director, I	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Home	5 Residence	6 Dether (Specify)
0 0	ng Pt fter tt ineral		27. Manper of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 1 Injury 28b. Time Injury	of 28c. Injury at 28d.	. Describe how in	
sio	death. ctor: A y the fu	catl	2 Accident investigation	M 1 Yes 2 No		
Division of Vital Records,	or Attendate death Director:	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, St.	and Number or Rural Route Number, ate)
ш	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	O	29a. Certifier 12 Certifying Physicien: To the best of my knowledge, dea	ath occurred at the time, date and place, and	due to the cause	e(s) and manner as stated.
	e Hos	edical	(Check only one) Medicel Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred a	at the time, date a	and place, and due to the cause(s)
	To the l within 2 To the I	Me	29b. Signature and title of certifier	29c. License number	29d. l	Date signed (Month, Day, Year)
			m full not	D40854	1	712612009
Ý	5/1		30. Name and address of person who completed cause of death (Item 23a) (Type		Baltine	म याग
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	5 Sparks		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** July 2004 6:00 A M James E, Jenkins, Sr. 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1917 Penhall Road Dundalk Mary1and If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 3,1919 North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 114M 2□ F 241-24-3409 85 Director Usual Residence of Decedent the Maryland Show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28e-f sho treumetic event, II a Medical Exact in at mast be notified at Maryland Baltimore Dunda1k Director 1 Tyes 2 TiNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1917 Penhall Road 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 MYes 2 □ No If Yes, Give Year or Date WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 9 Disabled N/A yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be and Mental Gertrude Rose James Lyon Jenkins ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 1 and 2 s of Health a 1917 Penhall Road Dundalk, Maryland 21222 Sandra Codish/ Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 = 0 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or once. Hilltop Service Corp. 7/26/2004 Towson, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. atephanie 10sser 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 MONTH S LUNG **Physician** CANCER OF disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or migury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 1 Yes 2 No 9 Unknown 9 🗌 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC UBSTRUCTIVE PULMONARY DISEASE page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSIO N autopsy performed? certificate 1 Tes 1 ☐ Yes 2 ☐ No 2 📉 60 Attending Physicien: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one. Hospital: Other: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Cutpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director; A completely filled in by the fi investigation 2 Accident 6 Could not be determined 3 D Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2004 033407. 10 IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUNDALK, MD WISE AVENUE SETH, M.D., DEEPAK. 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Hazel A. Kolodziejski 3:20pm July 27 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FutureCare - Canton Harbor n/a Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Pear) | Min. | March 31 , 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F 218-01-4263 89 Director PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show marked other than "natural", or items 23a or 28a-f sho imatic event, I've Muzical Examinar must be notified at MD Baltimore Essex 1 Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1007 Cherlyn Road 21221 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: δ Specify hite 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Operator Telephone Co 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental Hitlant: If Item 27 is marked off jury or other traumatic even Be ၉ Oliver Wingert Dora Muth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore Kolodziejski 1007 Cherlyn Road Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State permit. Pages i Department of H Important: If its any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MeadowridgeCemetery 7/30/04 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signatura of Funeral Service Licenses 300 Mace Ave. Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line: Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CVD **Physician** /Medical Due to (or as a consequence of) **Examiner** ANT DIJUME A LUULA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed OSTO ANTWIN 4 m Due to (or as a consequence of): Box 68760, Physician/Medical use as I IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 200 3 ☐ Probably 4 ☐ Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 autopsy performed 2□ No 1 Yes 2 No 1 Tes or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 No Certification: To 4 Voursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of D ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation I Director: A 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 SCALIA person who completed cause of death (Item 23a) (Type, Print won 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
BERNICE MARGARET 2. Date of Death **KRELL** Day Month **Physician** 8:00 P.M 25 JULY 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie North Arundel Anne Arunde Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖫 F 67 216-34-7456 Yrs. Director March 15 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other traumatic event, the Medical Examiner must be notified at Glen Burnie Md. Anne Arundel Co. 1 Yes 2 No Director 10e. Street and Number 7613 Turnbrook Road 10f. Zip Code 10g. Citizen of What Country? 21060 U.S.A. Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married "natural", or white 1 ☐ Yes 2 No Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry +2 College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any injury or other traumatic event, the Mean pages. Elementary/Secondary (0-12) Harms and Associates Secretary 18. Mother's Name (First, Middle, Maiden Sumame) Adelaide M. 17. Father's Name (First, Middle, Last) Be Holly Adelaide Bernard Η. Hornick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7613 Turnbrook Road, Glen Burnie, Md. 21060 19a. Informant's Name/Relationship (Type, Print) (Son) David K. Krell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 07/29/2004 Baltimore, Md. Cedar Hill Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER BLADDER **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☑No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 25 No 1 Tyes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 10 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0055973 N.D. TULY 25, 20P4 kassahun beleve 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11500 SUTHERLAND HILL WAY SINEL SPRING MO 20904 DESSE 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registra

DHMH 17 Rev 1/2001

Arell, Bernice

:		1. Decedent's Name (First, Middle, Last	")							2. Date of De		Year	3. Time of Dea
iysici Medic		JONATHAN	F. KEYS							JULY	23, Day 20		
kamin		4a. Facility Name (If not institution, give 900 ST DUNSTANS I				4b. City, To	BALT:	IMORI	E CI	ΓY	4c. Cou	nty of Dea	ath IA
neral ector		210 72 3100	X 7. Ag	e (In yrs. las	9 Yrs.	If Under 1 Months		If Under a	24 Hrs. Min,	8. Date of Bir OCT 14	, 1964	9. Bi	irthplace (State or For
***		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation					-		10d. Inside City Li
The d	ţō	MD NA			BA	LTIMOR	E						1 ∑ Yes 2 □
Exerciner rotat be notified at	Director	10e. Street and Number				10f. Zip C	Code				10g. Citizen	of What C	Country?
4		5306 MIDWOOD A	VENUE				21	212				USA	1
E E	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Deceder If Yes, specify	nt of Hisp y Cuban,	anic Orig	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14. F	Race - Am Black, Wh	terican Indian, lite, etc.
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	Physici /Medic		1. Decedent's Name (First, Middle, Last) Louis Karczes	ki, Jr.						2. Date of De July 2		2004 ^Y	ear	3. Time of Death	
	Examir		4a. Facility Name (If not institution, give to 13 Edgehill Court				Ве	l Aiı				c. County of Harfor	cd		
	Funeral Director		5. Social Security Number 6. Sep 1 219-38-2736	7. Age	(In yrs. last	birthday) Yrs.	If Under Months	Days	If Under 24 Hrs Hours Min.		th 19 Year 6,	1940	Birthpl Count Mar	ace (State or Fore Vland	gn
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	12 should h and Men 7 is marke traumatic	2	Louis Karczeski, 19a. Informant's Name/Relationship (Ty, Patricia Karczesł	pe, Print)	1				nd Number or Au	alwa Kan ura/Route Numbe el Air,	er, City	or Town, Sta	ite, Zip (Code)	
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f Vit	S S	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	ospital: 1 ☐ Inpatie	nt 2 ER/	Outpatient	3 DO	Othe	~	ith <i>(Check only o</i> ome 5 ,⊠ Resid		6 ☐Other (Specify)		
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Divi	= in the q		4 Homicide determined	28e. Place of Inju building, etc	. (Specify)					28f. Location (5 City or Tox	m, State	9)			
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one) 1 ★ Certifying Phys 2 ★ Medical Examination	sician: To the best of ner: On the basis of and manner sta	examination	dge, death and/or inv	occurred estigation,	at the time , in my opi	a, date and place nion, death occu	, and due to the or rred at the time, or	cause(s date and) and manne d place, and	r as stat due to t	ed. he cause(s)	
)	Tot Tot Com	M	29b. Signature and title of certifier	7 M	D			D30	number 6425		29d. Da 7	te signed (M	onth, Di	ay, Year)	
	10		39. Name and address of person who co Addm FAILL; ND	4C A	Jorth	Ave	Print)	Ste	425 ,	BelAi	r	MD.	210	14	
	Sta Registr		31. Date filed (Month, Pay, Year) JUL 28 200	325 Registra	r's Signature	4	W							b	

				State of Maryland / Department of Health and N 1 - State Registrer Certificate of Death	Mental Hy	/giene Reg. No. 0 ()		23747
		Physici	an	Decedent's Name (First, Middle, Last) JANIE LEMON	2. Date of D		Yeer	3. Time of Death 923 A M
		/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death May and Teneral Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	y Ky	4c. County o	Α	lace (State or Foreign try)
	Н	Funeral Director		217-20-7349 1□ M 2፟፟፟፟M F 85 Yrs. Months Days Hours Min. Usual Residence of Decedent	(Month, D	5 1919		ry) IH CAROLINA
		Aaryland show	or	10a. State 10b. County 10c. City, Town or Location			10	0d. Inside City Limits 1XXYes 2 □ No
		or 28a-l	Director	MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code		10g. Citizen of W		try?
	9	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "nsturs!, or items 23s or 28s-1 show other traumatic event, the Medical Examinst must be notified at	Funeral	14.01 N. LAKEWOOD AVENUE APT 202 21213 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Sive 1 Yes, Si	pecify Yes or N Rican, etc.)	U.S.A 14. Race Black Specify:	- Americ k, White,	etc.
rai	15-0036	n 72 hours natural', edical Exp	Completed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work if the DO NOT use retired)	king	16b. Kind of Bu	БЬА	
CA	d 212	be filed withintal Hygiene. Id other then	e Comp	Elementary/Secondary (0-12) College (1-4or 5+) 6th grade HOUSEWIFE		DOMEST		
~	Maryland	2 should be and Mental Is marked or raumatic eve	To Be	DAVE HUGGINS CARRIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rus	LEE SN		State Zio	Code)
5	, Mai	is 1 and 2 st of Health and item 27 is n other traun		Rosa Lee Lemon/Daughter 4738 Williston St., B	altimo	re, Maryl	and	21229
1/2	altimore	8 2 = 5		Westing of Disposition 3 □ Removal from State	2-04	BALTIMOR	-	
. 6	Balt	permit. Peges Department of Important: If is any injury or once.		21. Signature Funeral Service Licensee WILLIAM C BROWN COM 1206 W NORTH AVENUE	3		номе	P.A.
	8760,	Physician /Medical Examiner sthe pariet ransit	ai Examiner	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		ndary t	to	Approximate Interval Between Onset and Death
	P.O. Box 687	ne death certif the attending thed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 5 Other		23d. Dat Mor	e of delive	ory Day Year
1		quires that the signed by all do detact	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	i tobacco use contr] Yes 2 ☐ No	ribute to th 3 ☐ Prob	80
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	Division of	Attending P death. ctor: Afler t y the funera	Certification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Place of Injury - At home, farm, street, factory, office		e how injury occurr		d Route Number,
	Div	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		4 Homicide building, etc. (Specify)	City or T	own, State)		
		he Hosp n 24 hou he Fune pletely fil	Medical	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)		e, date and place, a	and due to	the cause(s)
		To t withi To tl	X	29b. Signature and title of certifier 29c. License number 89499		29d. Date signed 7/2	(Month,	Day, Year)
	'n			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 1	ospital	0	
		St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2. 8. 2004		/	•	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19b per FH C834 08/10/04dhb
State of Maryland / Department of Health and Mental Hygiene Amend item#19a per FH_C833 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Day Yeer Month **Physician** Clarice Laster JULY E121. 2004 6:38A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 215-30-7336 1 □ M 🛠 🗆 F Yrs. Sept. 24, 1932 Maryland Director 71 Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heatth and Mantal Hygiene.
shir if them 27 is marked other than "natural", or items 23a or 28e-1 show any or other treumatic event, ite Medical Examinar must be natified any or other treumatic event, ite Medical Examinar must be natified as Owings Mills 1 ☐ Yes -2 ☐ No Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21117 104 Pleasant Ridge Road #220 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ∐Yes 2√2No fYes, Give 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Custodian Public Schools 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Edward Jones Evelyn Johnson 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 21243

Princess Williamsd/ Daughter 1343 Kenton Road Baltimore, Maryland 21243 20c. Location - City or Town, State Park6/04 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arbutus Memorial 20a Method of Disposition permit. Pages the Department of Himportent: If ite any injury or ot once. Arbutus, Maryland 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lineasee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Paper. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** CARDIOGENIC SHOCK DAY /Medical resulting in death) Due to (or as a consequence of): Examiner CARDIOMYOPATHY Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medicai as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ò Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 🕱 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 2 No 4 Unknown 1 ☐ Yes METABOLIC ACIDOSIS Completed peed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 241 No 24a. Was an autopsy performed? page 2 certificate 1 Yes 2 No or Attending Physicien: uneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No P 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: After Injury 1 Natural 2 Accident 5 Pending investigation s after death. М 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number title of certi 29b. Signature a D 24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON MARYLAND 21204 7601 DSLER DRIVE TIMOTHY LOW M D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 8 2004

Registrar

			1 - For State Registrar		ryland / Dep Ce		of Hea	alth and I	-	giene		23749
	Physic	ian	1. Decedent's Name (First, Middle, Las						2. Date of De		Year	3. Time of Death
	/Medi			LENN	LINDSAY				JULY 2	5 2004		9:15 A M
	Examir	ner	4a. Facility Name (If not institution, give		-	-	_	cation of Death	1		ty of Death	
100			Mariner Health o				Burn					del Co.
9	Funeral Director		210 01 210)	7. Age	(In yrs. last birthday) 88 Yrs.	If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 06	th ly, Year) 1916		place (Stete or Foreign ortry) ch Carolina
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation						Od. Inside City Limits
	ne Maryli 8a-f sho piilied a	ctor	Md. Anne Aru	ndel Co.	Baltimo							1 ☐ Yes 2 🎇 No
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show 'te Medical Exaira ar must be notitled at	by Funeral Director	403 Waverly Ave.			10f. Zip 0	2122	25		10g. Citizen o	What Cour S.A.	ntry?
	r dea	ine	11. Maritat Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decede	nt of Hispa	inic Origin? (Sp	pecify Yes or No Rican, etc.)	14. Ra	ace - Americack, White,	
36	or It	y FL	1 ☐ Never Married 2 ☐ Married	1 Tyyes 2 □ No If Yes, Give	0	1 □ Yes 2		pecify:	7 (1041), 0(0.)	Spec		ite
8	urai',	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						3,000	ny. 11-1	
5	nati	lete	15. Decedent's Ed (Specify only highest grad	ication le completed)	16a. Dece (Give	dent's Usual kind of work	Occupation done during	n ng most of wor	king	16b. Kind of	Business/In	dustry
21215-0036	d withir giene. or than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	embly 1				General	Moto	rs
Maryland	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, I'm Me	To Be C	17. Father's Name (First, Middle, Last) Peter Edward	Lindsa	у		18.	Mother's Nam Atha	ne (First, Middle	Maiden Suma Harr		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show my highry or other treumatic event, If a Medical Examination and Legisla and DDCs.		19a. Informant's Name/Relationship (7) Anna M. Lindsay	урө. Print) (Wife)	19b. Mailii 403	ng Address (Wave	Street and	Number or Rus ve. Bal	ral Route Number timore,	or, City or Town Md. 21	n, State, Zip 225	Code)
Baltimore,	Pages 1 and of He ant; If item		20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	20b. Place of Dispo cemetery, cres Glen Have	esition (Name matory or oth en Mem	of erplace) orial	I	Date 7	20c. Location		
Balti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licens	Allina.	22	Name and McCul	Address of	Facility Olyniak	Funeral Ave. Bal	Home	P.A.	21225
68760,	Department of the second of th	edical Examiner	23a. Pan. Enter the disease, or composition, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Security at a modes if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a	consequence of):	er the mode	of dying, su	ach as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
.O. Box	at the death certific by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic preg Other (spec					ate of delive	ry Day Year
rds, P	w requires that been signed t should be det	by	Part II. Other significant conditions co	ntributing to death but		nderlying cau	se given in	Part I.	23e. Did to			e cause of death?
Vital Record	The la te has age 2	Completed								sy med?	prior to con death?	osy findings available npletion of cause of
ita	ician: 1 certifical ector, p	Bec	25. Was case referred to medical				26.	Place of Deat	1 ☐ Yes h (Check only o	2XNo	1 ∐ Yes	2) No
of	Phys this ral dii	Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H							ome 5 Resid	ence 6 🗆 Oti)
Division	ten leat tor: the	27. Manner of Death 1 Manural 2 Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28b. Place of Injury - At home, farm, street, factory, office 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28b. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28c. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28c. Date of Injury - At home, farm, street, factory, office								Route Number,		
Ω	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical Ce	Check only 2 Medicel Exami	sician: To the best of ner: On the basis of e	my knowledge, death	occurred at	the time, d	ate and place,	and due to the o	cause(s) and m	anner as sta	ated.
	To the within 2. To the complet	Med	5,	and manner state	ed.							
	5 × 5 0		29b. Signature and title of certifier	/			icense nur			29d. Date signe		. ,
	X		1	1 1	AD.	I.D	389	58		1 126	104	+
	6		30. Name and address of person of o co	L Silhu	ath (Item 23a) (Type, I	Print)	VAPO	LIS R	CAD #	106,00	tentos	n MD21113
	Sta Registr			32. Registrar'	a digitature	ash s				,		

DHMH 17 Rev 1/2001

ORIGINAL

04-4686 B.K.S MICHAET	L F. LAWRENCEPlease Type or	Print in Black Indelib	le Ink. Ensure All	Copies Are	e Legible.	
UNKNOWN 04-245	FOI	of Maryland / Departme		ntal Hygien	e O O O I	
	Registrar Unpend item #23, 1. Decedent's Name (First, Middle, Last)	27, perME, G834, 8/5	04 TT	Reg. No.	44 44	3. Time of Death
Physician /Medical	Michael F. La	iwrence		JULY 18	3, 2004	1542 P ^M
Examiner	4a. Facility Name (If not institution, give street and not ST.AGNES HOSPITAL		y, Town, or Location of Death ALTIMORE CITY	4	ic. County of Death	
Funeral Director	5. Social Security Number 6. Sex 2			Date of Birth (Month, Day Yea	9. Birth	place (State or Foreign http)
laryland show	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		, ,	1	10d. Inside City Limits
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Wher than "natural; or Items 23a or 28a-f show ant, the Madical Examinational be natified at a Completed by Funeral Director	10e. Street and Number	Baltimore	ip Code	100.0	itizen of What Cou	1 ☑ Yes 2 ☐ No
23a or unit ber	4642 Colherne Rd		71229	US		ntry?
i6 after death with or Items 23e or olicat notat be	Armed F	edent Ever in U.S. 13. Was Dec orces? If Yes, sp	edent of Hispanic Origin? (Speci ecify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	can Indian, etc.
ours aff	3 ☐ Widowed 4 ☐ Divorced	ive 1 Tyes	2 No Specify:		Specify: B/G	ick
ed within 72 hours atl system. To then "natural; or it, the Madical Exami	15. Decedent's Education (Specify only highest grade completed	Jife, DO NOT	ork done during most of working	16b.	Kind of Business/In	dustry
212: ad within agiene. er than i, tre M	Elementary/Secondary (0-12) College	(1-40r5+) Stock (Clerk	m	eat Pac	King Co.
E ed is by	17. Father's Name (First, Middle, Last) James Lawrence		18. Mother's Name (First, Middle, Maide Mar	on Sumame)	
Maryle nd 2 should lith and Mer 27 Is marke	19a, Informant's Name/Relationship (Type, Print)	- Father 4400	ss (Street and Number or Rural I	Route Number, City	1.11.1.	na
E = 14 F	20a. Method of Disposition	20b. Place of Disposition (N	ame of Date other place)	9 20c.	Location - City or To	MD 21133 own, State
ry free E	1 ☑ Burial 2 ☐ Gremation 3 ☐ Removal from '4 ☐ Donation 5 ☐ Other (Specify)	Loudon Park	7-23-0	14 Ba	1/timore	MD
Balt permit. Departr Imports any Inji	21. Signature / 5 neral Stance Licence	22. Name :	and Address of Facility	on Franchill	n prou Bo	Ito, mpala
	23a. Pahl. F ty the disease, or complications that shock, o heart failure. List only one cause on	caused the death. Do not enter the me	ode of dying, such as cardiac or r	espiratory arrest,	y rass me	Approximate Interval Between
Frysician - /Medical	Immedia cause (Final disease i condition resulting in death) a. Athe	rosclerotic Cardi				Onset and Death
Examiner	Due to	(or as a consequence of):				
keculed and I-transit	Sequentially list conditions, if any, leading to immediate caus a End of Lording Cause (Disease or injury	(or as a consequence of):				
O, executed an and rial-transit	that initiated events	(or as a consequence of):				
Box 68760, sath certificate be ex attending physicien for use as the burial cian/Medical Escian/Medical Es	d					
Box 68 leath certifical attending plant use as t	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, or	atcome of pregnancy			23d. Date of delive	
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be explired teach. After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as the buriary the funeral Transfer of the physician in by the funeral director.	in the past 12 months?	birth 2 ☐ Fetal death 3 ☐ Ectopic nant at time of death 5 ☐ Other (s			Month Month	Day Year
Division of Vital Records, P.O. I or Attending Physician: The law requires that the date desath. Director: After this certificate has been signed by the Jin by the funeral director, page 2 should be detached ertification: To Be Completed by Physician or Attention of the completed by Physician or Attention of the completed by Physician or Attention of the completed by Physician or Attention of the completed by Physician or Attention of the completed by Physician or Attention of the completed by Physician or Attention of the completed by Physician or Attention of the completed by Physician or Attention of the complete or Attention of the Complete or Attention of the complete	9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to contributing the contributing to contributing the contributing to contributing the contributing		cause given in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
ords equires ould be				1 ☐ Yes 2	2□No 3□Prob	ably 4 Unknown
Reccipient in the specific specific in the specific specific in the specific specific in the s				24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
/ital F	25. Was case referred to medical		26. Place of Death	performed? 1XYes 2□N	death?	2□ No
of Vi hysicl this cer al direct	examiner? 1 XYes 2 No Hospital: 1 □	Inpatient 2 ER/Outpatient 3 0	OA Other: 4 Nursing Home		6 □Other (Specify	')
On Conding Party (Affect of Funeral Innerty)	27. Manner of Death 1 Natural 5 Pending (Mor	of Injury 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	I. Describe how inju	ury occurred	
Division c tal or Attending P rs after death. all Director: Alfer t ed in by the tunera Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plac	e of Injury - At home, farm, street, facto ling, etc. (Specify)		Location (Street a City or Town, Stat	nd Number or Rura.	l Route Number,
		e best of my knowledge, death occurre	f at the time date and place and			
the Hospi thin 24 hou o the Funer impletely fill	(Check only XX Medical Examiner: On the t	pasis of examination and/or investigation	n, in my opinion, death occurred	at the time, date an	id place, and due to	the cause(s)
To t Your Your	29b. Signature and title of certifier Zalialia		O.C.M.E		ate signed (Month, L JLY 19, 2	
	30. Name and address of person who completed cau	se of death (Item 23a) (Type, Print)	reet, Baltimore	Marri	A 21201	
State	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	ree, partificte	, raryidi	RI ZIZUI	
Registrar	JUL 2 8 2004	w & sports				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.										
State of Maryl				Mental Hygie	ne					
1 - Stata Registrar	Cei	rtificate of D	eath	Reg.	NB. 1 1 1.	22751				
1. Decedent's Name (First, Middle, Last)				2. Date of Death	hal hal ag	3. Time of Death				
Helen Virginia Lowdermilk	2			Month 2	Day Year	11 01/11 M M				
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Le	ocation of Deat	h	4c. County of De	1 4 1 1 1 1				
FRANKLIN SQUARE HOSD	:Tal	Rose	1Ale		BAITI	MORE				
5. Social Security Number 9. Sex 7. Age (In)	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs Hours Min.		9 B	irtholace (State or Foreign				
235-14-8828 1□M 2XIF 81	Yrs.	Months Days	Hours IVIII.	Sept. 9,	922 Ma	ryland				
Usual Residence of Decedent 10a. State 10b. County 10c.	Ch. Two sale									
,	. City, Town or Lo					10d. Inside City Limits				
Maryland Baltimore	Per	ry Hall				1 □ Yes 2 No				
10e. Street and Number		10f. Zip Code		10g.	Citizen of What 0	Country?				
4027 Schroeder Avenue		21128			u.s.A.					
11. Marital Status 12. Was Decedent Ever i Armed Forces?	n U.S. 13. 1	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (S Mexican, Puer	Specify Yes or No-	14. Race - Am Black, Wh					
1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2 💢 No			Specify:	, , , , , , , , , , , , , , , , , , , ,		hite				
3 ☐ Widowed 4 ☐ Divorced Year or Dates:					Specify. W	nue				
15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occupation kind of work done dur	on ring most of wo	rking 16b	Kind of Busines	s/Industry				
Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade	life. I	DO NOT use retired) Homemaker			Own Hon	1e				
17. Father's Name (First, Middle, Last)		1/	8. Mother's Nar	ne (First, Middle, Maid						
Charles Frazee			Daisey	Mae Tho	mas					
19a. Informant's Name/Relationship (Type, Print) husband	() 19b. Mailir	ng Address (Street and		ıral Route Number, Cit		Zip Code)				
Mr. Robert L. Lowdermilk	4027	Schroeder	Ave.,	Perry Hall	. MD 21	128				
	b. Place of Dispo	The state of the s		Contract of the second	Location - City o	r Town, State				
21 X	st. Micha	zel Ch. Cer	n. 7/27	7/2004 Ba	ltimore,	, Maryland				
21. Signature Fulleral Service Licensee	22			himunek Fu						
(Y) Y (W)				Baltimore	, MD 212	36				
23a. Part1. Enter the disease or complications that caused the dishock, or hear failure. List only one cause on each line. Immediate Causé /Final disease or condition	eath. Do not ento					Approximate Interval Between Onset and Death				
resulting in death) a. Due to (or as a con	sequence of):	1 DisTRes	3 Jyiv	ANOME		48 HOURS				
Pueume	Pusumania									
Sequentially list conditions, if any, leading to immediate b. Due to (or as a son)	sequence of):									
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	T.18									
resulting in death) Last Due to (or as a con-	sequence of):									
u										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	elivery Day Year									
Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause given	in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?				
	•					robably 4 Dunknown				

Priysician /Medical Examiner

been signed by the attending physician and should be detached for use as the burial-transit

cate has i

this certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. Physician/Medical

þ

Completed

Be

P

Certification:

Medical

State Registrar

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that initiated ever resulting in death Examine

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, it is Madical Examination at once.

Hospital: 1 X Inpatient

24a. Was an autopsy performed? 2 No 1 ☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) 27. Manner of Death

1 Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

5 Pending investigation 6 Could not be determined

2 ER/Outpatient 3□ DQA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) М

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and

D0056296

29d. Date signed (Month, Day, Year) 7-23-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. JASON BIRNDA 31. Date filed (Month Day Year) 2004 2004 3 Begistrar's Signature Square DR, BAITIMORE Md 21237

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			1 _ For State	State of Maryland / Dep		Mental Hygie	ne	
	1 - Registrar Certificate of De					Reg.	No. 001 23752	
	Physici						Day Year	
	/Medi Examir		Ruth Dorothy L. 4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat	July 2	4. County of Death	
	LAGIIII		503 Deer Hollo		Mt. Airv			
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Frederick 9. Birthplace (State or Foreign Country)	
ш	Director		114-10-4175	□ M 2X F 86 Yrs.	Months Days Hours Min.	(Month, Day, Ye	1918 New York	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits	
	/anyli	5	MD Frederi				1 ☐ Yes 2 XNo	
	r 28a-f show	rect	10e. Street and Number	er Mt. All	Y 10f. Zip Code	100	Citizen of What Country?	
	23e or	Ö	503 Deer Hollo	w Drive	21771	139.	USA	
	ter deat	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcas?	. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,	
5-0036	2 o a	by	1 Never Married 2 Married 3 WWidowed 4 Divorced	1 ☐ Yes 2 ZNo If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puert 1 Yes 2X No Specify:	o Rican, etc.)	Black, White, etc. Specify: White	
5-0	72 hours "neturel", adical Exa	Completed	15. Decedent's Ec (Specify only highest gra		edent's Usual Occupation e kind of work done during most of wor	king 16b	. Kind of Business/Industry	
21	within ene. then "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	n'''g		
121	e filed within at Hygiene. I other then "	S	12 17. Father's Name (First, Middle, Last)		memaker		Own Home	
Maryland	t be find the of ed of	Be	T. William Kna			ne (First, Middle, Maid	len Sumame)	
Z	should be find Mental B marked of	၉	19a. Informant's Name/Relationship (7		ing Address (Street and Number or Ru	Powers	hear Town State Tin Code)	
Z	nd 2 sho alth and 1 27 is ma ir treume		Nancy Polansky				Airy, Md. 21771	
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. Place of Disp	osition (Name of	Date 20c.	Location - City or Town State	
Ë	Pages nent of int: if it		1 ☐ Burial 2 【ACremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	nemoval nom State	ash.Crematory	7/2004 _{Lat}	urel, Md.	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other <u>once</u> .		21. Signature of Funeral Service Licen	see / _//	22. Name and Address of Facility Wi	tzke Fune	eral Homes, Inc.	
			23a. Part1. Enter the disease, or comp	plications that caused the death. Do not en	o 55 TWIN KNOLLS	Rd, Coll	umbia, Md.21045 Approximate	
	/Medical Examiner bhysician and printing the printing street the p		Immediate Cause (Final	one cause on each line.		e	Interval Between Onset and Death	
		1	disease or condition resulting in death)	a. Pue to (or as a consequence of):	ENOUS LEVEL	177	3 MONTHS	
		ner		MY ELO DYSPLASTIC	ENOUS LEUKER SYNAROME		4 months	
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
		edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of the					
50,	oe exectan e	Ĕ	resulting in death) cast	Due to (or as a consequence of):				
68760,	cate l	dica		d				
	leath certifi attending		IF FEMALE:	23c. If yes, outcome of pregnancy			2010	
Вох	atten atten i for u	23b. Was decedent pregnant in the past 12 months? Solution of pregnancy 23d. Date of delivery 1						
O 24 € 5 9 □ Unknown 9 □ Unknown								
٠ <u>.</u>	res that igned b	by PI	Part II. Other significant conditions or	ontributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?	
Records,	w require been sig should b			· · · · · · · · · · · · · · · · · · ·		1 🗆 Yes	2 No 3 Probably 4 Unknown	
000	ie law requ has been je 2 shouli	plet				24a. Was an	24b. Were autopsy findings available	
	The laste has page	Completed				autopsy performed? 1 ☐ Yes 2 🛣		
/ita	d cien : Th certificate rector, pag	Be (25. Was case referred to medical examiner?			th (Check only one)		
of Vital	Physicien: rthis certifica ral director, I	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Residence 6 Other (Specify)				
	or Attending Physicien: after death. Director: After this certific in by the funeral director,	lon	27. Manner of Teath 1 Matural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	jury occurred	
Division	or Attencater death Director: in by the	Icat	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	29f Loanting (Street	and Mumber on Division Development	
Ξ	I or Attendi after death. Director: A I in by the fu	Certification;	4 Homicide determined					
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	vsician: To the best of my knowledge, deal iner: On the basis of examination and/or in	th occurred at the time, date and place, evestigation, in my opinion, death occur	and due to the cause(red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)	
	o the		29b. Signature and title of certifier (7)	and manner stated.	29c. License number	29d. D	Date signed (Month, Day, Year)	
	Margh Count up D3(761					29d. Date signed (Month, Day, Year) 7/26/04 7/26/04 7/26/04 7/26/04		
	9	4						
	り		BRIAN M. OG	completed cause of death (Item 23a) (Type,	W. SEVENTH SI	T. FRE	SERICK MD 21701	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 1	/	/	

			1- For State of Maryland / Department of Health Certificate of Deal	th	giene Reg. No. () () ()	23753
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day, Year	3. Time of Death
	/Medic Examir	al	Doris McDonald 4a. Facility Neme (If not institution, give street and number) 3 Duralumin Court Middle 1		4c. County of Death	
	Funeral Director			nder 24 Hrs. 8. Date of Birl	Baltimo	nplace (State or Foreign
	anyland show	٦٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Middle Rive			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show roust be notified at	Funeral Director	10e. Street and Number 3 Duralumin Court 10f. Zip Code 21220		10g. Citizen of What Co	
36	be filed within 72 hours after death with the Marylar Ital Hygiene. Ind Hygiene. Indicate than "natural", or items 23s or 28s-f show other than "natural", or items 23s or 28s-f show event, the Madical Examiner rust be natified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No Spec 1 □ Yes 2 ☑ No Spec 1 □ Yes 2 ☑ No Spec			, etc.
Maryland 21215-0036	swithin 72 hou jiene. r than "nature the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9th	most of working	16b. Kind of Business/I	ndustry
yland 2	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Max	To Be C	John McIntosh V:	other's Name (First, Middle, ictoria		
	2 = 2 -		19a. Informant's Name/Relationship (Type, Print) Lori Clark / daughter 3 Duralumin (Court Middl	e River M	D
Baltimore,	Pa anti-		20a. Method of Disposition 1	J	Parsons W	
Bal	permit. Pa Departmen Important: any injury	4	21. Signature of Funeral Service Licensee 22. Name and Address of Fa	ace Ave. Ba		D 21221
	Enysician /Medical		23a. Pan'i. Enter the disease, or combications that caused the death. The not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. FAST	TIC CANC		Approximate Interval Between Onset and Death
),	Examiner	Examiner	Due to (or as a consequence of):			
.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of deliving Month	ery Day Year
rds, P	w requires that been signed to should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I. 23e. Did to	obacco use contribute to es 20No 3□ Pro	
Il Records,	The ate h page	Completed		24a. Was a autop perfor	sy prior to co	opsy findings available impletion of cause of
on of Vital	iing Physician: The la n. After this certificate has funeral director, page 2	ion; To Be	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4	28d. Describe h	ne) ence 6 ⊡Other <i>(Speci</i> ow injury occurred	(y)
Division of	To the Hospital or Attsnding Ph within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		itreet and Number or Run n, State)	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir.	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date (Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, dand manner stated.	death occurred at the time, of	late and place, and due t	o the cause(s)
)		2	29b. Signature and title of certifier 29c. License number 29c. License	5/	29d. Date signed (Month, Tuly 23,	2004
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHBEL ACCERBACH, 9/10 Philabel Phila Description of the Complete Country of the Complete Country of the Country	Ro #314	Boltimace	21237
	Sta Registr	_	31. Date filed (Month, Day, Year) 32 Registrar's Signature 4 South			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer **Physician** 5:15a^M July 25 2004 Mary Α. McNeal /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number, Examiner Ivy Hall Nursing Center Baltimore 8. Date of Birth (Month, Day, Year)
June 28, 1936 Marylam Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 XF Months 228-26-7044 68 Director Usual Residence of Decedent deeth with the Maryland 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State or than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at Baltimore 1 Yes 2 No MD Essex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 USA 861 Sue Grove Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify:White 1 ☐ Yes 2 █XNo Completed by 3 Xi Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than *r any injury or other traumatic avent, tra Mad pinca. Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Labedzidski Adam Gryclik ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wesley McNeal Jr./son 1200 Cord Street Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State OakLawnCemetery 7/28/04 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility ConnellyFuneralHomeofEssex 02 300 Mace Ave. Baltimore MD 21221 Part1. Enter the disease, or per fications that caused the deal + En not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lin only tine cause on each line. Interval Between Onset and Death Small Immediate Cause (Final Cell with metastaris Ling Cancere **Physician** im-Known disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): attending physician Physician/Medical thel IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? emia 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 1 Yes 2 No 2 12 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician: or Attending death. the Director: filled in by within 24 hours. To the Funerel

Baltimore, Maryland 21215-0036

State Registrar

Medical

4 Homicide

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASEEM. 709-BAS 32. Registrar's Signature

t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

709 BASTERN BLVD.

29d. Date signed (Month, Dey, Year)

MD-21221

07-26-2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 52PM **Physician** 200 100Ne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKIN Hospita Timore Year If Under 24 Hrs. 4 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 20 F -56-162 Director Yrs. Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medicul Evertine round be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Itimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ST 603 212 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕱 No Specify Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12+h OME man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 5 William MODNE 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Moth er 20b. Place of Disposition (Name of cemetery, crematory or other place) 420 ace 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Ba 5 ☐ Other (Specify) ie 22. Name and Address of Facility ase, or complication re. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ise on each line. 23a. Part1. Enter the discount failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Pheumonia Sequentially list conditions, Examine day leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit the attending physician and Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 X No Division of Vital 1 ☐ Yes 2 ☐ No ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient within 24 hours after death. To the Funeral Director: After this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) GEORAS ASJOC, PROFOR 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) there Geors MED. D41805 26/04

State Registrar 31. Date filed (Month, Day, Year)

31. Date filed (Month, Day, Year)

37. deg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THATC, SSOL Hopkins

32 Registrar's Signature

104

Barview

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2 Date of Death Year **Physician** MORRIS ORRAINE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BACTIMORE SECOURS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. 7(Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country), **Funeral** 219-40-8702 1 M 2 3 Months Days Yrs. Director mary land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "neturel", or Items 23e or 28a-f shov other traumatic event, the Medical Examinar institue or confined at 1 Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ellamont 21216 USA 1030 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No ρ Specify: Black 3 ₩idowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filad within nent of Health and Mental Hygiene. int: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Care 10th Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johnson William Harris ouise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monroe Ave. Balto, mo 1907 Kichara 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory -31-04 21. Signature Funeral FH 270 Fredhilton Pass Balto, mb 21229 JOHY P. March of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** acute myocardia disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physicien and the for use as the burial-transit Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 - No 1 Yes in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ျ 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 Matural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \)

To the Hospitel or Attending Physicien: within 24 hours a To the Funaral D

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760.

death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

ical

29a. Certifier (Check only one)

KOSITA

29b. Signature and title of certifier

cause of day (Item 23a) (Type, Print)

M-D

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

KON

32. Registrar's Signature

Hospitel or Attending Physicien: Certification: death. Director: filled in by

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 X No

7/18/2004 investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Found of 9:05 28d. Describe how injury occurred Subject ingested ethylene glycol 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number Road City of Town, State 813 Joppa Farm Road Joppa, Maryland

Found at residence 29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

O.C.M.E.

July 19, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Registrar

JUL 2 8 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

within 24 hours a

To the Funerel E

completely filled i

Medical

			1 - For State Registrar	State of	Maryla		artmen rtificat			ind M	lental Hy	giene	004	23	758
	Physic	ion	1. Decedent's Name (First, Middle, L	ast)	-						2. Date of Dea	ath Day	V	3. Tim	ne of Death
	/Medi		Agnes Mo	rris							July	26	2004	8:3	BOPM M
	Exami	ner	4a. Facility Name (If not institution, gi	ive street and numb	er)		4b. City,	Town, or	Location of	f Death		4c.	County of Dea		
			Ruxton of Pikesv				I	Pikes	sville				Baltin	nore	
	Funeral			Sex 7. 1 ☐ M 21 ☐ F		. last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birti (Month, Day	h y, Year)	9. Bi	thplace (Sta	ate or Foreign
	Director		Usual Residence of Decedent	- X -	96	Yrs.					Sept. 2	8,19	07		/A
	land		10a. State 10b. County		10c. C	city, Town or Lo	cation					_		10d Insid	e City Limits
	Mary f sh	ō	MD D - 14.	.	Ì										Yes 2 XNo
	28a	rec	MD Balt 10e. Street and Number	imore		P1	lkesvi					10a Citia	zen of What C		-
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	death ms 2	Funeral Director	22 Randall Ave	12. Was Decede	nt Ever in l	J.S. 13. 1	Was Deced	2120 lent of Hi		in? (Spe	cify Yes or No-		USA 4. Race - Ame	nican Indian	
9	or Ita	F	1 X Never Married 2 ☐ Married	Armed Force	es? ☑ No	1	_		n, Mexican,	Puèrto I	cify Yes or No- Rican, etc.)		Black, Whi	e, etc.	',
9	ral', c	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	is:		1 ☐ Yes 2	2 X I No	Specify:				Specify: Wh	nite	
5-0	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-f show int, the Mydical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gi	ducation		16a. Deced	dent's Usua	I Occupa	ition	of work is		16b. Kin	d of Business	/Industry	
21	ithin	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	lite.	DO NOT us	e retired)	uring most	OF WORK!	ng				
2	ed wygier ygier her th		7			As	sista	nt E	Buyer			1	Retail		
ng L	be fill	Be	17. Father's Name (First, Middle, Las	t)					18. Mother	's Name	(First, Middle,	Maiden S	Sumame)		
<u>\</u>	2 should be filed withir and Mental Hygiene. ia marked other than aumatic evant, I.e.M.	2	Richard Morris								Sacra				
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Heath and Mental Hygiene. If itam 27 is marked other than "natural", or itams 23s or 28s-f show or other traumatic event, If a Madical Examiner must be notified at		19a. Informant's Name/Relationship			19b. Mailin	ng Address	(Street a	nd Number	or Rura	Route Number	r, City or	Town, State, 2	Zip Code)	
	ges 1 and of Health if itam 27 or other tr		Yvonne Hubbard 20a. Method of Disposition	Niec		31 M	lary1a	nd A	ve.,		sville,				
ō	Pages nent of H int: if its iry or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	Removal from Sta	ite	Place of Dispo cemetery, cren	natory`or ot	her place	9)	D	ate	20c. Loc	ation - City or	Town, State	
Ë	t. Pa tmer tant:				Car	rroll C				/27/	04	Har	npstead	, MD	
Baltimore,	permit. Pag Department Important: f eny injury o		21. Signature of Funeral Service Lice	nsee C					s of Facility				tersto		
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	Fnysician /Medical Examiner	Iner	23a. Part1. Enter the disease, or come shock, or heart fahere. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a	I NA as a consec	quence of):					n Ace		5013	Approxin Interval I Onset ar	Between
ox 68760,	the death certificate be executed y the attending physician and iched for use as the buriat-transit	√Medical Examiner	resulting in death) Last	C											
P.O. Box	at the death by the atter rtached for u	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death 3 🗌	Ectopic pre Other (spe					23	d. Date of deli Month	very Day	Year
Records, F	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions (contributing to death	but not res	ulting in the un	derlying ca	use giver	n in Part I.			acco use	e contribute to		if death? Unknown
-	The ate h page	Completed							-14-km-	_	24a. Was ar autopsy perform 1 Yes 2	ned?	24b. Were au prior to c death? 1 \(\text{Yes}	opsy finding ompletion of 2 \(\text{No}\)	s available cause of
Vital		Be	25. Was case referred to medical examiner?	Hospital:				044	100	f Death	(Check only one	9)			
	Phys r this ral di	. To	1 Yes 2 No 27. Manner of Death	1 ∐ Inpa 28a. Date of In		ER/Outpatient 28b. Time of		1	Jursi		e 5 Reside			ify)	
no	ding I h. After funer	tou	1 ☐ Natural 5 ☐ Pending	(Month, E	Day Year)	Injury		c. Injury a			3d. Describe ho	w injury o	occurred		
Si	Attanding In death. actor: After by the funer	lica	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		niunc - At ho	omo farm atra	M		es 2□No		26 1				
=	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the funer	Il Certification:	4 ☐ Homicide determined		etc. (Specif	ý) 					Bf. Location (Str. City or Town,	State)			imber,
	24 hc 24 hc Fun stely	edical	(Check only 2 Medical Exam	ysician: To the bes niner: On the basis and manners	or examina	iwiedge, death ition and/or invi	occurred at estigation, i	the time n my opir	, date and p nion, death (occurrec	id due to the ca I at the time, da	use(s) ar te and pl	nd manner as: lace, and due:	stated. to the cause	(s)
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		For State Registrar	110400	State of Marylar	•	nt of Health and te of Death		giene	23760
Phys /Me Exan	dical	1. Decedent's	Name (First, Middle, Last) On ne (If not institution, give s.	reet and number),	4b. <i>Sj</i> it	Martin r, Town, or Location of Dea	2. Date of De Month		12:16A M
Funera Directo	al		rity Number 6/Sex	M 2 XF 7. Age In yrs.	last birthday) HO Yrs. If Und Month	or 1 Year If Under 24 Hr. Days Hours Mir	S. 8. Day of Bir (Nonth, Da	iv, Year)	Birthplace (State or Foreign Country)
Maryland I-f show	tor	10a. State	ce of Decedent 10b. County		ty, Town or Location	DRIA			10d. Inside City Limits 1 ☐ Yes 2 No
ath with the 23a or 28e ust be not	Funeral Director	10e. Street and 3605	DERWOO	D LANE #	202 2	ip Code 22309		10g. Citizen of What	•
5-0036 72 hours after death with the Maryland naturel', or itema 23a or 28a-f show ocal Examiner must be notitied at	by	11. Marital Sta 1 Never	Married 2☐ Married	 Was Decedent Ever in U Armed Forces? 1 ☐ Yes 1 ☐ Yes, Give Year or Dates: 		edent of Hispanic Origin? (ecity Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	Black, W	merican Indian, /hite, etc. BLACK
vithin 72 hours affilene. Than "neturel; or the Workel Exami	Completed	-	15. Decedent's Educ Specify only highest grade Secondary (0-12)	ation completed) College (1-4or 5+)	life. DO NOT	ork done during most of w	orking	HEACT	•
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. In the standard other than "nature!", or fleme 23a or 28a-f show any Injury or other traumatte event, the Michael Examiner must be notified at	To Be Co	1	ame (First, Middle, Last) TT HARD	4		18. Mother's Na	ent Jo		
and 2 sho ealth and m 27 ts m		19a. Informan	t's Name/Relationship (Typ IE HARDY (MOTHER)	868 E	ss (Street and Number or F	· BKLY	N, NY. 112	202
Baltimore Dermit. Pages 1 is Department of He mportant: If Itan			f Disposition I 2 □ Cremation 3 □ Ro tion 5 □ Other (Specify)	emoval from State	Place of Disposition (A cemetery, crematory of SEHILL CE	me of other place) METERY 8	2/04	20c. Location · City LINDEN	or Town, State, New JERSKY
Baltim permit. Pag Department Important:	- Suce	21. Signature	of Funeral Service Vicense	ure .	22. Name 4905	and Address of Facility V	· BAUL	C GREENE MORE, MD.	ENDERAL SOU
Physicia /Medic		23a. Part1. E shock, o Immediate Ca disease or co resulting in de	r head failure. List only on ause (Final ndition	cations that caused the deale cause on each line. Cerebral Due to (or as a conse-	Edema	ode of dying, such as cardi	ac or respiratory a	trrest,	Approximate Interval Between Onset and Death 3 days
3760, at the burial-transit or in burial-transit or	ical Examiner	Sequentially I if any, leading cause. Enter Cause (Disea that initiated e resulting in de	se or injury events c	Due to (or as a conse	quence of):	-je			4 days
Box 68 death certific e ettending p od for use as i	by Physician/Med	in the pa	edent pregnant st 12 months? 2 \(\sigma \) No	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 □Ectopic			23d. Date of Month	delivery Day Year
ords, P.O requires that the een signed by the		Part II. Other		tributing to death but not re	sulting in the underlying	cause given in Part I.			e to the cause of death? Probably 4 Unknown
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	7		d address of person who co	MDPkD mpleted cause of death (Ite	om 23a) (Type, Print)	RES-000 Street Baltim		July 27 2 21287	P00
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Section Sect	idings available on of cause of
25. Was case referred to medical examiner? 1	10
Top Top	
27. Manner of Death 28d. Describe how injury occurred	
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29a. Certifier 29a. C	ause(s)
and manner stated. 29d. Date signed (Month, Day, Young to be a signed to be a signed to b	'ear)
D27740 7/20/2004	
30. Name of address of person who completed cause of death (Item 23a) (Type, Print)	
Robert A. Palermo, M.D. GBMC 6701 N. Charles Street; Baltimore MD 21204 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar JUL 2 8 2004 Some & spouls	

			1 - For Amend Item	State of M 23a per D	aryland / Der			Mental Hy	giene Reg. No. 1	23762
	Physic /Medi		Decedent's Name (First, Middle, Last James Thomas Moos	e, Sr.				2. Date of De July	Day Ye	3. Time of Death 1230 A. M.
	Exami	ner	4a. Fecility Name (If not institution, give	street and number)	. 1	4b. City, Town	, or Location of Dea	ith	4c. County of D	Peath
				ARR HO	SPITAL	Lose	PALE		BA LT	imore
	Funeral Director		5. Social Security Number 6. Se	ex 7.Ag SakM 2.□F	ie (Mr yrs. last birthda) 79 - Yrs.	y) If Under 1 Year Months Day		. (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	_		212-28-2355 Usual Residence of Decedent					April 3	3, 1925 No	orth Carolina
	rylan rhow	_	10a. State 10b. County		10c. City, Town or I	Location				10d. Inside City Limits
S	e Ma Ba-f s	cto	Maryland Baltimor	е	Dundall	ζ				1 ☐ Yes 2√√No
DA ME	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-1 show other traumetic event, the Mydical Examinar must be notified at	Funeral Director	10e. Street and Number 2706 Gray Manor T			10f. Zip Code 2122			10g. Citizen of What United St	
X	items	nue	11. Marital Status	12. Was Decedent Armed Forces?		. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Jban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race - A Black, W	merican Indian, Vhite, etc.
336	hours aft	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 ☐ I If Yes, Give Year or Dates:		1□ Yes 2√√N			Specify W h	ite
7	in 72	Completed	15. Decedent's Edu (Specify only highest grad	fe completed)	(Giv	edent's Usual Occ re kind of work don DO NDT use retir	e during most of w	orking	16b. Kind of Busine	ss/Industry
212	f within liene. r then "	omp	Elementary/Secondary (0-12) 11 yrs	College (1-4or 5	o+)	llurgical	•		Ch 1	T
and	e filed Il Hygid other	BeC	17. Father's Name (First, Middle, Last)		Ticcas	raurgicai		me (First, Middle,	Maiden Surname)	Industry
ja ja	should be filed within and Mental Hygiene. is marked other then aumetic event, Ire M.	ToE	Roy Monroe Moo	se			Minnie	e M. Perr	:y	
and Series	2 should and Men is marke sumetic		19a. Informant's Name/Relationship (T)				et and Number or F	ural Route Numbe	or, City or Town, State	
O €,	1 and Health term 27		Elizabeth Gardner	Moose/Wi		and the same of th	nor Terra	-	alk, Maryl	and 21222
- Jorg			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F		20b. Place of Disposers, creeding Holly Hil	amatory or other of	lace)	Date (2004 N	20c. Location - City	
altim	it. Partimer intant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of the eral Service 1 c	~ \ //		_		5/2004 F	Tagie Kiv	er, Maryland
- Ba	permit. Page Department of Important: If any injury or once.		Mally.	Inll	5 7	/922 Wise	Funeral Avenue I	Baltimore	Dundalk, Marylan	Inc. d 21222
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	lications that caused ne cause on each lir	the death. Do not er	nter the mode of dy	ying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ratory Fa					Onset and Death
	Examiner			Bye to (or as	a consequence of):	Respirate	ory Acido	sis	,	
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Que to (or as	a consequence of):	Pnetmoni	a	W.E.		
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	- Hos	Direct	RIA	Cloud	osis		
o,	an an rial-tr		resulting in death) Last	Due to (or as	a consequence of):	12	0.00	0010		
Box 68760,	ate be hysici he bu	Icai		mei	LMON	+0				
	ieath certifica attending ph i for use as th	Physician/Med	IF FEMALE:							
Bo	ath catherdather	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	су		23d. Date of d Month	delivery Day Year
P.O.	that the de led by the a detached	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5	Other (specify)			Month	Day Toal
م ر	or Attending Physician: The law requires that the death certificate be executed that death. Director: After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant conditions cor	ntributing to death bu	ut not resulting in the t	underlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Division of Vital Records,	w require been sig should b							1 🗆 Y	es 2 No 3 1	Probably 4 Hinknown
ပ္ပ	e law re has be je 2 sho	plet						24a. Was a		autopsy findings available
<u> </u>	The ate has page	Completed	/		/			autops perfor	med? death?	o completion of cause of ? es 2 \(\sum \) No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to nedical examiner?					ath (Check only or		75 22110
of \	Physic this c	2	1 105 2 340	fospital: 1 1 patier		III JUDON		fome 5 ☐ Reside	ence 6 □Other (Sp	pecify)
u	ding I	lon	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	Wo		28d. Describe ho	ow injury occurred	
18.	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Inju	rry - At home, farm, st		Yes 2 No	28f. Location (Si	troot and Alumber en	D I D Al L
D.	al or Attendir s after death. i Director: Af d in by the fu	Certification:	4 Homicide determined	building, etc	. (Specify)	reer, ractory, ornice		City or Town	treet and Number or I n, State)	Hurai Houte Number,
	To the Hospital or Attending Ph within 24 hours atler death. To the Funerel Director: Atler th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of ner: On the basis of and manner sta	of my knowledge, deat examination and/or in	th occurred at the to	ime, date and place opinion, death occu	, and due to the caured at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
_	ro the	Me	29b. Signature and title of certifier	A Mailian SIA	<i>r</i>		se number		9d. Date signed (Mor	
	iVA		· (////	inal -		RE	5000		7-14	- 24
	UP		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Type,		2000		1 4	- 0 1
	10		DR. Hossein Ar	edeha	11-900	10 Frank	JIN Sau	ARe Drive	Baltimo	Ve, MD. 21237
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature		. \			
	riegisti		1111 B B 684	The second	A PARIL	-				

Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Mo

m.D

4 32. Registrar's Signati

111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

Registrar

		For State	State of Maryland / D	epartment of Certificate o			giene Reg. NS. N N L	22765
		1. Decedent's Name (First, Middle, I		Oor imodic o	Dodin	2. Date of Dea	ath	3. Time of Death
Physicia		REGINA AND	ERSON ROEDEL			July 2	Day Year 26. 2004	2:18 P M
/Medic Examin		4a. Facility Name (If not institution, g		4b. City, Town	n, or Location of D	7	4c. County of Dea	
		STELLA MARIS H			monium		Baltimor	
Funeral			Sex 7. Age (In yrs. last birt	Months Day		Min. 8. Date of Birt (Month, Da	y, Year) Co	hplace (State or Foreign buntry)
Director		220-20-0841 Usual Residence of Decedent	80 Y			Mar 28	, 1924 Ma	ryland
death with the Maryland ms 23a or 28a-f show fraust be notified at		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
e Mar	ctor	Maryland Baltime	ore County I	Parkville				1 ☐ Yes 2 No
ith th	Director	10e. Street and Number		10f. Zip Code	ө		10g. Citizen of What Co	ountry?
s 23s		8800 01d Harfor		140 140 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21234	2./S	USA 14. Race - Ame	since to dia-
iten de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify C	uban, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	Black, Whit	
urs af	þ	3 ₩idowed 4 Divorced	If Yes, Give A Year or Dates:	1 □ Yes 2 ∏ N	No Specify:		Specify: 7	Mhite
LIZIS-UUSO d within 72 hours after death with the Maryian jlane, rthan "natural", or Items 23a, or 28a-f show the Modeal Examiner mast be mullited at	Completed	15. Decedent's (Specify only highest of		Decedent's Usual Occ (Give kind of work do	cupation ne during most of	workina	16b. Kind of Business	Industry
A High	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use ret	ired)			
J Z Z		17. Father's Name (First, Middle, La		Homemaker	18 Mother's	Name (First, Middle,	Own Resid	dence
d be filed and he filed sheat Hyg) Be	James Charles				ie Ray	maiddir garramo)	
d Mari	ပ	19a. Informant's Name/Relationship		Mailing Address (Stre			or, City or Town, State, 2	Zip Code)
and 2 s and 2 s ealth an m 27 le		Mr. James C. And	lerson (Brother) 3	Benningia	m Road.	Convent S	Station NJ	07960
of Hear		20a. Method of Disposition	20b. Place of	Disposition (Name of crematory or other p		Date	20c. Location · City or	Town, State
Pages nent of ant: If it ury or o		1 ☐ Burial 2 TCremation 3 1 ☐ Donation 5 ☐ Other (Special Control of Contro	city) Green	Mount Ceme	etery 7/	28/2004	Baltimore,	Maryland
Daltimor permit. Pages Depertment of I important: if its any injury or o		21. Signature of Fundral Service in	ensee Luwm	22 Name and Add	dress of Facility		1 Home, Inc	
D 80553		Martin D. La						100
Section 1		shock, or heart failure. List on	mplications that caused the death. Do n ly one cause on each line.	ot enter the mode of d	tying, such as car	rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aINANITION					
Examiner		1	Due to (or as a consequence of	f):				
	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of	f):				-
uted	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events	C					
6 / 6U, cate be executed bhysician and the burial-transit		resulting in death) Last	Due to (or as a consequence of	f):		-		
ate be e	dicai		d					
death certificate e attending phys d for use as the	Mec	IF FEMALE:	220 If you gutoome of progpancy					
box of leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐Ectopic pregnar			23d. Date of del Month	very Day Year
that tha de led by the a detached f	ysic	1 □ Yes 2 X No 9 □ Unknown	9 Unknown	3 Cities (Specify)				
that the deta	by Ph	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
w requires that been signed be should be deta						1□Y	es 2 □ No 3 □ Pr	obably 4XJUnknown
2 0 0	ompleted					24a. Was a	an 24b. Were au	topsy findings available completion of cause of
The I						perfor	med? death?	2 □ No
r VITAI HEO yalcien: The lav is certificate has director, page 2	BeC	25. Was case referred to medical examiner?				Death (Check only or	ne)	
60 KV 173	일	1 ☐ Yes 2 🗙 No	Hospital: 1 Inpatient 2 ER/Out				ence 6 Ther (Spec	HOSPICE
	lon:	27. Manner of Death 1 Natural 5 ☐ Pending		jury V	ijuryat Vork? □Yes 2 □No	28d. Describe h	ow injury occurred	
JIVISION I or Attending after death. Director: After	ertification;	2 Accident investigat 3 Suicide 6 Could not	be 300 Blood of Injury - At home for			28f. Location (S	itreet and Number or Ru	ral Route Number.
l or A aftar Dire	ertii	4 ☐ Homicide determine	building, etc. (Specify)	, and a second		City or Tow		
UNUSIC To the Hospitel or Attency within 24 hours after death To the Funerel Director: completely filled in by the	alc	29a. Certifier 1 ☐ Certifying	Physician: To the best of my knowledge,	death occurred at the	time, date and p	lace, and due to the o	cause(s) and manner as	stated.
n 24 I n 24 I he Fu cletely	edical	(Check only 2 Medical Ex	aminer: On the basis of examination and and manner stated.	vor investigation, in m	y opinion, death o	occurred at the time, o	date and place, and due	to the cause(s)
Withi To t	Σ	29b. Signature and title of certifier		29c. Lice	ense number		29d. Date signed (Month	n, Day, Year)
,6			/1-	DC	13/2	5	1/27	104
1			o completed cause of death (Item 23a) (, ,	
Sta	te	DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)	OD 2300 DULANEY V. 32. Registrar's Signature	ALLEY RD.	TIMONIU	JM, MD 2109	93	
Registr		JUL 2 8 2004	1 .	Sparker	,			

DHMH 17 Rev 1/2001

REGINA ROEDEL

ORIGINAL

DOUGLAS STRONG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

- State Registrar 1. Decedent's Name (First, Middle, La. Douglas McAut 4a. Facility Name (If not institution, g Stella Maris 5. Social Security Number 248-38-9995 Usual Residence of Decedent 10a. State 10b. County Maryland Balti 10e. Street and Number 2 Trotters Cou 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorcedent's (Specify only highest g Elementary/Secondary (0-12) N/A 17. Father's Name (First, Middle, La. David P. Stron 19a. Informant's Name/Relationship Barbara Crosby	hur Strong ive street and number) HOSPICE Sex 1 M 2 F 61 100 more 12. Was Decedent Ever Armed Forces? 1 Yes, Give Year or Dates: Education rade completed) College (1-4or 5+)	yrs. last birthday, Yrs. c. City, Town or L Pi in U.S. 13.	Timo: If Under 1 Year Months Days	r Location of Death nium If Under 24 Hrs. Hours Min.	2. Date of De Month July 1 8. Date of Bir (Month, Da July 2	Day 8, 2 4c.	County of Death Baltim 9. Birth Cou	nore splace (State or Foreignity) Carolin 10d. Inside City Limit 1 □ Yes 東京N
Douglas McAut 4a. Facility Name (If not institution, g Stella Maris 5. Social Security Number 248-38-9995 Usual Residence of Decedent 10a. State 10b. County Maryland Balti 10e. Street and Number 2 Trotters Cou 11. Marital Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g Elementary/Secondary (0-12) N/A 17. Father's Name (First, Middle, Lat. David P. Stron 19a. Informant's Name/Relationship	hur Strong ive street and number) HOSPICE Sex 1 M 2 F 61 100 more 12. Was Decedent Ever Armed Forces? 1 Yes, Give Year or Dates: Education rade completed) College (1-4or 5+)	Yrs. c. City, Town or L Pi in U.S. 13.	Timo: If Under 1 Year Months Days ocation kesville 10f. Zip Code 2120 Was Decedent of H If Yes, specify Cube	nium If Under 24 Hrs. Hours Min.	Month July 1 8. Date of Bir (Month, Da July 2	Day 8, 2 4c.	County of Death Baltim 9. Birth Cou 1942 S	Nore Place (State or Foreigntry) Carolin 10d. Inside City Limit
4a. Facility Name (If not institution, g Stella Maris 5. Social Security Number 248-38-9995 Usual Residence of Decedent 10a. State 10b. County Maryland Balti 10e. Street and Number 2 Trotters Cott 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g Elementary/Secondary (0-12) N/A 17. Father's Name (First, Middle, Lat. David P. Stror 19a. Informant's Name/Relationship	HOSPICE Sex 7. Age (In form) The second of the second of	Yrs. c. City, Town or L Pi in U.S. 13.	Timo: If Under 1 Year Months Days ocation kesville 10f. Zip Code 2120 Was Decedent of H If Yes, specify Cube	nium If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	4c. th y, Year)	County of Death Baltim 9. Birth Cou 1942 S	Nore Place (State or Foreintry) Carolin 10d. Inside City Limi 1 Yes
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15. Decedent's (Specify only highest g Elementary/Secondary (0-12) N/A 17. Father's Name (First, Middle, Lateral David P. Stron 19a. Informant's Name/Relationship	Education grade completed) College (1-4or 5+)	16a. Dece	X	Specify:	riican, etc.)	1	Black, White, Specify: B1	_
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N/A 17. Father's Name (First, Middle, La: David P. Stror 19a. Informant's Name/Relationship		life	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	king	16b. Kir	nd of Business/Ir	idustry
17. Father's Name (First, Middle, Last David P. Stron 19a. Informant's Name/Relationship	st)		er Emplo	_		Dis	sabled	
19a. Informant's Name/Relationship		Meve	T PUDIO	18. Mother's Nam	e (First, Middle,	Maiden	Sumame)	
	ng			Bertha	L. Wo	rthy	Y	
		19b. Maili 1 0 1 4	ing Address (Street R	and Number or Rui oad Bal	timore	, Maı	r Town, State, Zij ryland	21212
20a. Method of Disposition		0b. Place of Dispo	matory or other plan	ا (م	Date		cation - City or T	
1√ Burial 2 ☐ Cremation 3 • 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State cify)	woodlaw	n Cemet	ery 7/2	4/04			Maryland
21. Signature of Funeral Service Lig	ersee	2	2. Name and Addres	ss of Facility Ch	atman-	Har	ris Ful	neral H
Dery An	vi .						THOTE'	nd 212.
23a. Part Finder the disease, or co shock, or heart failure. List on	mplications that caused the ty one cause on each line.	death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	a GLIOBLAST	OMA						Onoot and Doam
resulting in death)	Due to (or as a con	nsequence of):						
Sequentially list conditions,	b. — Due to (or as a cor	nsequence of):						
cause. Enter Underlying Cause (Disease of Injury							- 0	
resulting in death) Last	Due to (or as a cor	nsequence of):			•			
•	d							
IC COMAL C.								
23b. Was decedent pregnant	1 ☐ Live birth 2 ☐	Fetal death 3[2		rery Day Year
1 ☐ Yes 2 ☐ No	4□Pregnant at time 9□Unknown	of death 5[Other (specify)				WOILLI	Duy Tous
	contributing to death but no	t resulting in the t	inderlying cause give	en in Part I.	23e. Did to	obacco u	se contribute to t	the cause of death?
	3	•	, 3		1 🗆 1	∕es 2□	□No 3□Prot	bably 4 X Unkno
					24a Was	an	24h Were auto	onsy findings availa
					autop perfo	ssy rmed?	prior to co death?	empletion of cause of
25. Was case referred to medical	1			26 Place of Deat			1 Ll Yes	2∐ No
examiner?	Hospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth				N Other (Specif	y) HOSPICE
27. Manner of Death		28b. Time o	of 28c. Injun					, HODI IOI
2 Accident investigati	ion	,,						
	289. Place of injury -	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Tox	Street and vn, State)	d Number or Rura	al Route Number,
X	4			W				
(Check only 2 Medical Ex	aminer: On the basis of examiner							
29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	1		T	777		7	119/00	4
30. Name and address of person wh	6	(Item 23a) (Type	Print)	2177		-/	11/	<u></u>
SS. TEING ENG EGGIOSS OF POISON WIT		(202) (1)90,						
F = 2 2	23a. Part Enter the disease, or co shock, or heaf failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 2 Accident 3 Suicide 4 Homicide Could not determine 29a. Certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 20b. Signature 20b.	23a. Party Enter the disease, or complications that caused the shock, or head failure. List only one cause on each line. 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Name and Address of Facility Ch 52 40 Reisterstow 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heaf failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CLIOBLASTOMA Due to (or as a consequence of): b. Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. 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Do not enter the mode of dying, such as cardiac or respiratory a section, or heaf failure. List only one cause on each line. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a section, or neath and the death. 23b. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and the death. 23c. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and the death. 25c. Live start of the death. 25	22. Name and Address of Facility Chatman—Har 5240 Reisterstown Rd Balt 23a. Part/Enter by disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sends, or theat failure. List only one cause on each line. Immediate Cause (Final diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sends, or heart failure. List only one cause on each line. Immediate Cause (Final diseases or conditions) a. CLIOBLASTOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. Place of Death 1 Yes 2 No 24a. Whs an a sutposty performed? 1 Yes 2 No 25c. Was case referred to medical examiner? 1 Yes 2 No 25d. Was case referred to medical examiner? 1 Yes 2 No 25d. Was case referred to medical examiner? 25d. Describe how injury 25d. Describe how injur	22. Name and Address of Facility Chatman—Harris Full 5240 Reisterstown Rd Baltimore, 10 5240 Reisterstown Rd Baltimore, 1

Registrar DHMH 17 Rev 1/2001

		1 - For State Registrar	lease		of Marylan	nd / Dep		t of H	ealth a		lental Hy		001.	237	167
		1. Decedent's Name (First	, Middle, Las	et)							2. Date of De Month	ath Day	Year	3. Time of	Death
Physic /Med		Virginia		К.		Sherm	an				July	26	2004	7:05	рМ
Exam		4a. Facility Name (If not in							Location o	of Death			ounty of Death		
		Heritage H					Anna If Under	apol:	LS If Under:	24 Hrs	8. Date of Bir	41-	ne Arur	l /C4-4	r Foreign
Funera Directo		5. Social Security Number 174–18–305	- 11	л □м 2\С ХГ	7. Age (In yrs. 85	Yis.	Months		Hours	Min.	(Month, Da	9 Year)	19 Penr	lace (State of	n i a
		Usual Residence of Deced									0027	.,			
nylani how		10a. State 10b.	County		10c. Cit	ty, Town or Lo	ocation						1	0d. Inside Ci	-
C 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28e-f show on, the Masical Examera must be notifiled at	Director		ne Aru	ndel	(Odento								1 🗆 Yes	26X140
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fter d	Funeral	1 Never Married 2	☐ Married	Armed F	orces? 2.171No					, Puèrto	ecify Yes or No Rican, etc.)		Black, White,	etc.	
O36	by	3 X Widowed 4 □ D	ivorced	If Yes, G Year or D	ve)ates:		1 ☐ Yes	2 LON NO	Specify:			S	pecify: Wh	ite	
5-0 72 hc	Completed	15. Do (Specify only	ecedent's Ed highest grad	lucation de completed)		(Give	dent's Usua kind of wo	rk done a	luring most	t of worki	ing	16b. Kind	of Business/Inc	dustry	
Man of the control of	Id m	Elementary/Secondary	(0-12)	College (1-4or 5+)		DO NOT us	se retired,)			Fodo	rol Cor		- -
Hygie ther t	ပိ	12 17. Father's Name (First, I	Middle, Last)			Secre	etary		18. Mothe	r's Name	(First, Middle		ral Gov	ernmen	ונ
E gebà	To Be	Ellsworth							M	vrt1	e Snyde	r			
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28e-f ehow traumatic event, the Madical Examinar must be notified at	-	19a. Informant's Name/Re	elationship (7	Type, Print)		19b. Maili	ng Address	(Street a					own, State, Zip	Code)	
12 5 € Z		Patricia M.	Wight	man (F	riend)	500	Lisa	Ave	nue,	0den	ton, M	2111	.3		
or Head		20a. Method of Disposition 1X Burial 2 ☐ Cren		Removal from	1 ,	Place of Dispo cemetery, cre	osition (Nar matory or o	ne of ther place	9)		Date	20c. Loca	tion - City or To	wn, State	
Itimore, iii. Pages 1 ar intment of Hea intant: if item injury or other		`4 □Donation 5 □C				Lington			,	-	/2004		ngton,	VA	
Baltimol permit. Pages Department of Important: If i any injury or once.		21. Signature of Fundal S	Service Licen	SOO Al		2	2. Name an Harde 12 R	d Addres esty idge	Fune:	ral :	Home, P	A.	MD 214	01	
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ed sit	ine	Sequentially list condition if any, leading to immedia cause. Enter underlying Cause (Disease or injury	itė 🐇	Pue to	(or as a conseq	puence (f):		His	» //	Pul	MAGA	n	DiF	a.	P
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Vital F iician: Th certificate rector, pag	ပိ	25. Was case referred to	medical						os Placa	of Dooth	1 Yes	21 No	1 🗆 Yes	2 No	
Vision of Vital Attending Physician: 1 r death. ector: After this certificat by the funeral director, p	To B	examiner?	induiou.	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DC	Othe	1				Other (Specify	,)	-117
Division of a lor Attending Phys after death. Director: After this in by the funeral dir	n: T	27. Manner of Death		28a. Date		28b. Time o		8c. Injury Work	at		28d. Describe			/	
Oivision or Attending later death. Director: After in by the funer	Certification:	2 Accident	Pending investigation		, Duy . 027	,,	М		/es 2 □ I	No					
Division Attender de Directe	rtiflo	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Plac	of Injury - At hi		reet, factory	y, office			28f. Location (. City or Tox	Street and I wn, State)	Number or Rura	Route Num	ber,
Division of Vital Revision of Vital Revision of Vital Revision to the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Cel	29a. Certifier 1000	ertifuing Dh	veicion. To th	e best of my kno	aulodaa daal	h occurred	at the tim	n data an	d place	and due to the	221122(2) 21	ad mannos oo at	atad	
To the Hospital within 24 hours a To the Funeral I completely filled	edicai			niner: On the I	pasis of examina nner stated.)
To th within To th comp	Me	29b. Signature and title of	ertifier	V) D		^	290	. License	number	4 -		29d. Date :	signed (Month, i	Qay, Year)	
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//	9	30. Name and address of	pysyl who	completed cau	e of death (Iter	n 23a) (Type	Print)	1/5.	05	1117	F 326	Ci.	In d	PRINC	2.1
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S Regis	tate trar			Real	registrar #Signa	ALGIO A	K a								
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	1-	For State Registrar	riease	-		nd / Depa		lealth and N Death	Mental Hygi		04	2376	8
Physician /Medical	1	Decedent's Name (I HEN R.I Facility Name (II no	SQU	ITIER			4b. City, Town, o	r Location of Death	2. Date of Death Month JULY	22_	Year 2004 nty of Death	3. Time of De	M M
Funeral Director	j. 5.	N IVERS: TY C Social Security Num 97–44–266	DF MARY	AND LIET	XCAL CO	last birthday) Yrs.	BALT I MO If Under 1 Year Months Days		8. Date of Birth (Month, Day, June 27,		N/A 9. Birthp	lace (State or Fitry) sylvania	oreign
vith the Maryland to 728a-f show ke notified at Director	10	a. State 1 a. State 1 aryland 6 e. Street and Number	Ob.County Baltim	ore		ity, Town or Lo			10)g. Citizen	of What Coun	0d. Inside City t 1 ☐ Yes 2	
er death with tems 23a o	11.	1215 Over Marital Status Never Married Widowed 4	cbrook 2X Married	Road 12. Was Dece Armed Fo. 1 ☐ Yes, If Yes, Giv	rces? 2 XNo e			21239 Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	E	U.S.A Race - Americ Black, White, o	an Indian,	
Maryland 21215-0036 nd 2 should be filed within 72 hours att tht and Mental Hygiene. 27 is marked other then "natural", or reteumatic event, the Medical Exami To Re Completed by F		15	5. Decedent's E only highest gi	1	-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work d)	sing		f Business/Ind	dustry	
laryland 2121 2 should be filed within and Mental Hygiene, is marked other then eumatic event, the M	3 17	. Father's Name (Fil Henry 9a. Informant's Nam		Squitier	i	19b. Maili	ng Address (Street	18. Mother's Nam Elsie and Number or Rui		lodzar	nowski	Code)	
re, s 1 ar f Hee item other	20	Margaret A a. Method of Dispos 1 Burial 2 34 Donation 5	sition Cremation 3	☐Removal from	State	Place of Disponder		cθ) itory 7-2	7-04 I	oc. Location	on-City or To	wn, State Iaryland	1
Baltimo permit. Page Department o Importent: if any injury or		1. Signature of Fune Jerry 3a. Part 1. Enter the shock, or heart	1 fer	rane-	aused the dea		tor occu	ess of Facility Wiedefeld k Road I ng, such as cardiac	saltimore	e. Mar	e, Inc.	Approximate Interval Between	en
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Cords, P.(w requires that the bean signed by should be detacted by Physical B	Pa	art II. Other significa	ant conditions	contributing to d	eath but not re	sulting in the u	nderlying cause gi	ven in Part I.		acco use c		ably 4 Unk	
Vital Record lician: The law requir certificate has been si rector, page 2 should		5. Was case referre	d to medical					26. Place of Dea	24a. Was ar autops perform 1 Yes 2	ned?	prior to cor death?	psy findings ava npletion of caus	ailable se of
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examin	2	examiner? 1 Yes 2 No. 7. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigate 6 Could not determine	28a. Date (Mon be 28e. Place	of Injury th, Day Year)	28b. Time of Injury home, farm, st	f 28c. Inju	her: 4 🗌 Nursing H	ome 5 Reside 28d. Describe ho 28f. Location (Str. City or Town	nce 6 1 winjury oc	curred		r,
the Hospitei of thin 24 hours a thin 24 hours a the Funerel Empletely filled impletely filled i		9a. Certifier 1 (Check only 2 one)	Certifying F	aminer: On the b and man	asis of examir ner stated.	nation and/or in	ivestigation, in my	ime, date and place opinion, death occu	rred at the time, da	ite and plac	ce, and due to	the cause(s)	
To the comp		9b. Signature and till	a Dey	Su Su su completed caus	rgical	sesidon em 23a) (Type	ct P-1	se number 1748	8	od. Date sig July Tinic	gned (Month, 22)	Day, Year) 2004 15	
State Registral	3	CAURA 1. Date filed (Month)	KEN	DRA ?	_ 0	vg :	Sparks	LEMENT.	ST	212	30		

			_ For	State of Ma	ryland / Dep			Mental Hy	giene	11 00260
			State Registrar 1. Decedent's Name (First, Middle, I	acth	Ce	rtificate of	Death	2. Date of Dea	Reg. No. U	3. Time of Death
	Physici		LOILBERT	SPEER	1			Month	Day /	Yeer 1800 M
	/Medic Examin		4a. Facility Name (If not institution, g		2	4b. City, Town,	or Location of Deat	h	4c. County	
			100	HOSPITAL (ENTER	-	If Under 24 Hrs	Lo Data of Dist		timore_
	Funeral Director		5. Social Security Number 216-16-2327	.Sex 7.Age 1M2 M 2□ F	(In yrs. last birthday 83 Yrs.	Months Days	Hours Min.	8. Date of Birt	1920	9. Birthplece (State or Foreign Country) MD
100			Usuel Residence of Decedent							10d. Inside City Limits
	arylar ehow	5	10a. State 10b. County MD BAL	TIMORE	10c. City, Town or L	OCATION DALLSTOWN				1 ☐ Yes 2 ☑ No
	28a-f	rect	10e. Street and Number	TIMORE	NAMI	10f. Zip Code			10g. Citizen of W	
	within 72 hours after death with the Maryland ene. Itan "natural", or Itame 23e or 28e-f ehow Ita Madical Examinar must be mailliad at	Funeral Director	9401 EDWAY COUR	Т			21133			USA
	ltame	uner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race Black	e - American Indian, k, White, etc.
36	irs afte	by F	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🔀 No	Specify:		Specify	WHITE
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21215-0036	d within 72 ho piene. r than "natui the Wed Fall	Completed	Elementary/Secondary (0-12)	4 College (1-4or 5-	-1	DO NOT use retire	ed)		CARPET	
CA	Hygi Hygi ther	Be Co	17. Father's Name (First, Middle, La		0.12		18. Mother's Na	me (First, Middle,		е)
/lan	o d a b	To B	NATHAN		SPE		YETTA			DUBOWITZ
Maryland	and and is m		19a. Informant's Name/Relationship ETHEL SPEERT /	(Турө, Print) WIFE		ing Address (Street				
	1 and Healt Healt Hem 2		20a. Method of Disposition	WILE	20b. Place of Disp	100	1	Date		City or Town, State
Ē	Pages nent of int: If it iry or o		1 X Burial 2 □ Cremation 3 1 4 □ Dopation 5 □ Other (Spe		ARLINGTO		I_	/27/2004	BALT	IMORE, MD
Baltimore,	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Lie	cense		2. Name and Addre				OS., INC.
	70E = 9		TO LOUDY	mulications hat caused						Approximate Interval Between
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AL	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	TURE (11101	RACIC	HOXIIC	. MUZU	RYSIM
	Examiner		Sequentially list conditions.	b. ATH	COSCL consequence of):	eronc	HEA)	T 1de	sease	
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8760,	ate be hysicia the bu	dical		d						
89 X	leath certificat attending phy I for use as the	/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date	e of delivery
Box	The law requires that the death certifical ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant at		□Ectopic pregnanc □ Other <i>(specify)</i> _	;y		Mor	
P.0	that the debt the detached	Phys	9 Unknown	9□ Unknown			una ia Dant I	23a Dida	phaceo use contr	ibute to the cause of death?
	signed I	by	Part II. Other significant condition	s contributing to death bu	it not resulting in the	ungenying cause gi	verim Parti.			3 ☐ Probably 4 ☐ Unknown
Records,	w requir been si should	Completed						24a. Was		Vere autopsy findings available
Re	The lay	omo						autop perto 1 ☐ Yes	rmed? d	rior to completion of cause of leath? Yes 2 No
Vital	ysician: The is certificate hi director, page	Bec	25. Was case referred to medical examiner?	1		0.		ath (Check only o	ne)	
of		-T	1 Yes 2 No	Hospital: 1 Inpaties 28a. Date of Injur	-	ent 3 DOA		dome 5 Resid	dence 6 Other	
	nding Ph ith. :: After th e funeral	atlon	1 Natural 5 Pending 2 Accident Investiga	(Month, Day		Wo	ork?]Yes 2.∐No			
Division	I or Attandi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin		ry - At home, farm, s	treet, factory, office		28f. Location (S City or Tox		er or Rural Route Number,
Q	pital o		29a. Certifier Certifying	Physician: To the best of	f my knowledge, dea	th occurred at the t	ime, date and place	and due to the	cause(s) and mar	nner as stated
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune.	Medical	(Check only 2 Medical Ex	ceminer: On the basis of and manner sta	examination and/or i	nvestigation, in my	opinion, death occ	urred at the time.	date and place, a	and due to the cause(s)
	To th withir To th comp	Ň	29b. Signature and title of certifier	. / 5 /		29c. Licen	se number		29d. Date signed	(Month. Dey, Year)
,			Jusau		eus, M	Delan D	22751	1015	Jul 1	Prod
	Y		30. Name and address of person w	NEST	SPITAL	CENTER	R F	4010	STOIDL	Ma ZIISA
	Sta		31. Date filed (Month, Day, Year)		r's Signature	Sports)		
	Regist	rar	JUL 2 8 20	104 pm	~	Jan Jan				

			1 - For State Registrar	State of I	Marylan		artment rtificate			ind Me	ental Hygi	iene	0.1	00770
		н	Decedent's Name (First, Middle, Las	t)							2. Date of Deat	-	U4-	3. Time of Death
	Physici /Medio		Eileen A. Tynan								July	23, 20	004^{Par}	1:45 PM
)	Examin		4a. Fecility Name (If not institution, give	street and number	er)		4b. City,	Town, or	Location of	Death			y of Death	
			5554 Oakland Ro	ad			A 20 h					Bal:	timor	e
	Funeral		5. Social Security Number 6. Se	x 7.	Age (In yrs. I	last birthday)	If Under		If Under 2	4 Hrs.	8. Date of Birth		9. Birth	plece (State or Foreign
58	Director		218-22-0184	☐M 2121F	87	Yrs.	Months	Days	Hours	Min.	oct 21,	1916	Mary.	lánd
	P ,		Usual Residence of Decedent		10 0									
	anyla shov	_	10a. State 10b. County			y, Town or Lo	cation						1	10d. Inside City Limits
	8a-f	cto	Maryland Baltimor	e	Arb	utus								1 ☐ Yes 2 ☑ No
	ith th	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of	What Cour	ntry?
	ath v	<u>ra</u>	5554 Oakland Road				21	227				USA		
	ar de tams	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	S. 13. V	Vas Decedi Yes, speci	ent of His	spanic Origi n, Mexican,	in? (Spec	ify Yes or No- ican, etc.)		ce - Americk, White,	can Indian,
36	s afte	by F	1 Never Married 2 Married	1 Tes 2 [If Yes, Give	11		☐ Yes 2		Specify:				y. Wh:	
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7	within ene.	Ĕ	Elementary/Secondary (0-12)	College (1-4d	or 5+)		memak	,				Orm	. Home	
	e filed within al Hygiene. I other then vent, the Me		17. Father's Name (First, Middle, Last)			110	memar		18. Mother	's Name /	First, Middle, M			<u> </u>
Maryland	Mental Mental arked o	To Be	Charles L. Brown											
Z	2 should and Men is marks aumatic	-	19a. Informant's Name/Relationship (T	rpe, Print)		19b. Mailin	a Address	(Street at			ecelia Route Number,			Code
	01 02 25 25		Alfred J. Tynan		Son						butus,			
J.	Health Health tem 27		20a. Method of Disposition		20b, PI	ace of Dispos	sition (Name	e of		Da Da		Oc. Location		
10	Pages nent of int: If it iry or o		1 XBurial 2 Cremation 3 □I 3 4 □Donation 5 □Other (Specify,		t e	emetery, crem rison	-		1	/20/				
altimore,		. 8	21. Signature of Funeral Service Licens		Gai		Name and	_		1291	2004 00	vings I	11.1.1.S	, Maryland
Ba	permit. Departr importa sny inju		Pate S.a	tula		S1 73	erlin 6 Edm	ng As ionds	shton on Av	Schv enue	vab Fune ; Caton	ral Ho sville	me, MD	Inc. 21228
П	*		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caus ne cause on each	ed the death line.	. Do not ente	or the mode	of dying,	such as ca	ardiac or	respiratory arres	St.		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a lith by	0,501	ROTI	ē.Ca	Rdio	1/150	1/24		¿ 20 05-		Ohsel and Death
	/Medical Examiner		resulting in death)	Due to (or a	a consequ	ence of):	7	******	VAJC	ردم بري	,	125-121:	-	1-119
	Examine	_	Sequentially list conditions,	b										/
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequ	ence of):								
	and I-tran	хап	that initiated events resulting in death) Last	Due to for a	as a consequ	anna of):								
8760,	cate be executed physician and the burial-transit	E		000 10 (01 8	as a consequ	erice (ii).								
87	phys the	dlcai	•	d							<u>.</u>			
9 X	that the death certific ed by the attending p detached for use as	Physiclan/Me	IF FEMALE:	3c. If yes, outcom	no of progna									
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o	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		atn 5 🗆	Other (spec	crty)						
ص	that the by detail	유	Part II. Other significant conditions co.	ntributing to death	but not resul	lting in the un	derlying car	use aiven	in Part I		23e Did toba	cco use cont	ribute to th	ne cause of death?
Records,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	d by				3 -	acriying out	acc great				_/		ably 4 □Unknown
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ě	has has	ш								_	24a. Was an autopsy		prior to con	psy findings available appletion of cause of
_											performe		death?	2□ No
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	Phys this ral di	- To	1 Yes 2 No 27. Manny of Death	1 Inpa		R/Outpatient 28b. Time of			4 Nursi		5 Residen)
S	ding h. After funer	틸	1 atural 5 Pending	(Month, E	ay Year)	Injury	M 200	c. Injury a Work?			d. Describe how	injury occurr	ed	
Division of	Attending in death.	Ica	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of I	niuny - At hon	no farm stro			s 2 No		Landing (Ct.)			
2	after Dire	ertiflcation:	4 Homicide determined	building,	etc. (Specify)	ine, raini, stre	et, lactory,	omce		201	City or Town,	et and Numbi State)	ar or Hurai	Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To tha Funeral Director: After th completely filled in by the funeral	O	29a. Certifier 1 Certifying Physics	sician: To the bes	st of my know	vledge death	Occurred at	the time	date and	nlace acc	d due to the er	en(e) =======		
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check miy 2 Medical Exami	ner: On the basis and manner:	of examination	on and/or inve	estigation, in	n my opir	nion, death	occurred	at the time, date	and place, a	ind due to	the cause(s)
	To th within To th compl	Me	29b. Signature de alla of certifier			5	29c.	License r	number		29d	Date signed	(Month, E	Day, Year)
) (ATIII).	Bussa	50 M	(17)	-	0		11		die.	27.	2001/
	4		30. Name and address of person who co	impleted cause of	déath (llém	23a) (Type 0	rint)	1		11	W	014/	-/,	2004
	7		E.P.W.II.	an Co	W Va.	2022	350	Jak	NS 1	0-	EF1	1.6.	1	101
	Stat	te	31. Date filed (Month, Day, Year) JUL 2 8 2004	32. Regis	trar's Signati	1701	/	- 00	//	1	1-6	ma	RUI	2000
	Registra	ar	JUL 2 8 2004	Denge	- /	1 14	porks					21111	70	10 10 KZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month July 2004 Year **Physician** 25, Patricia Dee Tretter 1:56pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Fairhaven Health Care Center Sykesville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 12, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Duntry) IN 1 □ M 2 💢 F 76 Yrs. 1928 262-38-0942 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other then "naturel", or items 23a or 28a-f shov traumatic event, in a Medical Exeminar must be notified at 1 ☐ Yes 2 X No Sykesville Carroll Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21784 7200 Third Avenue A-202 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iter any injury or other traumatic event, the Medical Exempra once. 17 Yes 2 No If Yes, Give 1 Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Baltimore, Maryland 21215-0036 1950-53 þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Goddis David R. Sample 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45 Edmondson Ridge Rd., Catonsville, MD 21228 Mrs. Joan M. French (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem. 7/28/04 Crownsville, MD 21. Signature Juneral Service Licenses 22 Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PO Box 195)
Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metaltatic breast Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the sequence of the Examiner Due to (or as a consequence of): death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) The law requires that the cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 No 1 Tyes 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2/4 Division of Vital : After this certifica a funeral director, p or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral I
completely filled To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Terrifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of sertifier D0059 054 6 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7200 Third Avenue, Sykesville, MD 21784

State Registrar 31. Date filed (Month, Day, Year) JUL 2 8 2004

Dr. Ana Saranre, M.D.

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year navles VOI 10:34 AM Ldward 2004 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical univ of Baltimore Vy 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 X M 2 □ F Yrs Director 216-28-4599 May 20, MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location iem 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at 10d. Inside City Limits Director 1 Yes 2 No PA York Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai <u>6 Magnolia Lane</u> <u> 17331</u> USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, tha Medis 200.9. (Specify only highest grade completed) MD Transportation Elementary/Secondary (0-12) College (1-4or 5+) <u>Police Captain</u> Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles E. Voll, Sr. Madeline Franey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth L. Voll Wife 6 Magnolia Lane, Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 7/29/04 Hanover, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cancer Mua /Medical Due to (or and consequence of): Examiner Prostate cancer - metastatic to spine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner inding physician and use as the burial-transit death certificate be executed Due to (or as a consequence of): the attending physician an/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Physici 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed been s 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 1 Hnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 2 🗆 No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AU4176435 15237 30. Name and address of Ferson who completed cause of death (Item 23a) (Type, Print) univ MD Med 31. Date filed (Month, Day, Year) **JUL 2 8** 2004 Registrar

			1 - For State Registrar		ryland / Dep	artment of Healt	th and Men	-	ne	23773
	Physici	an	1. Decedent's Name (First, Middle, Las	()				Date of Death Month	Day Year	3. Time of Death
	/Medi		EDWARD WYATT				3	ULY	26 2004	1741 M
4	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or Locat	tion of Death		4c. County of Dea	th
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday	BALTIMORE If Under 1 Year If Ur	nder 24 Hrs. 8. [Date of Birth	Q Rin	tholace (State or Foreign
	Funeral Director		-	QM 2□F 7	Yrs.	Months Days Hou	urs Min. (Month, Day, Ye		thplace (State or Foreign ountry)
	pu ,		Usual Residence of Decedent					7007173	J 1181)	
	anyla shov	5	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 Y Yes 2 □ No
	the M	ect	Maryland 10e. Street and Number		Baltimo			10-	000	
	with Sa or		3605 Elmley Avenue			10f. Zip Code 21213			Citizen of What Co	ountry?
	death ms 2;	Funeral Director	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Specify		S.A. 14. Race - Ame	erican Indian,
9	or Ita	Ē	1 Never Married 2 Married	Armed Forces? 1X Yes 2 ☐ No If Yes, Give	1953			n, etc.)	Black, Whit	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Itams 23a or 28a-1 show to Medical Evarth or matter redified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1955	1 ☐ Yes 2X No Spe	эспу:		Specify: B1	.ack
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12	withir ene. than	дшс	Elementary/Secondary (0-12)	College (1-4or 5+)	kerman			BG&E	
	should be filed within and Mental Hygiene. s marked other than " umatic event, ILE MES	Be Co	17. Father's Name (First, Middle, Last)		101		Nother's Name (Fir			
<u>lar</u>	uld be Aenta rked tic ev	To B	Earl Wyatt			Dor	rothy Hoc	ker		
Maryland	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any fajury or other traumatic event, the Medical Evernities for mast be rediffed at once.		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mail	ng Address (Street and Nu	umber or Rural Ro	ute Number, Ci	ty or Town, State, 2	Zip Code)
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ore	Pages 1 nent of H int: If ital		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State		matory or other place)	Date		. Location - City or	
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Ba	permit. Departr Importa any inji		21. Signature of Funeral Service Lice	-	46	11 Park Hgts	acimyThe De	errick (Baltimo	C. Jones	F/H, P.A.
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Ö,	e exe		resulting in death) Last	•	consequence of):					
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9 x	leath certifica attending plants of for use as t	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				22d Date of dal	
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	Day Year
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ď.	res tha igned I be det	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause given in Pr	art I.	23e. Did tobaco	co use contribute to	the cause of death?
ord	w require been sign							1 🗌 Yes	2 □ No 3 ₽ Pr	obably 4 Unknown
Records,	e law r has be je 2 sh	Completed						24a. Was an autopsy		topsy findings available completion of cause of
-	: The cate his page	Con					1	performed 1 □ Yes 2 ☑	death?	
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	Place of Death (Ch			
of	Phys r this ral di	1: To	1 Yes 2 No 27. Manufer of Death	1 ☑ Inpatient	2 ER/Outpatie	11 3 DOA 4L		5 Residence	6 ☐Other (Spec	cify)
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Visi	Attandi er death, ractor: A by the fu	Hice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	/- At home, farm, st	reet, factory, office	28f. L	ocation (Street	and Number or Ru	ral Route Number,
Ö	tal or A	Certification;	- I (TOTALOGE	building, etc.	(эрвспу)		(City or Town, St	ate)	
	To the Hospital or Attanwithin 24 hours after deation to the Funaral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	sician: To the best of iner: On the basis of e and manner state	xamination and/or in	h occurred at the time, date vestigation, in my opinion,	e and place, and d death occurred at	lue to the cause the time, date :	e(s) and manner as and place, and due	stated. to the cause(s)
	To ti withii To ti comp	M	29b. Signature and title of certifier			29c. License numb	per	29d. I	Date signed (Month	n, Day, Year)
			166 h			15859		١	uly 26,20	104
1,	χ,		30. Name and address of person who c	ompleted cause of dea	ith (Item 23a) (Type,					
1			BRIAN EDWARDS		cene S-	BALTIMORE 1	MD 21230			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s signature	backs				

hysici		1. Decedent's Name (First, Middle	a. Last)			-			2. Qate of D	Reg <u>√N</u> c eath	4	3. Time of Deat
/Medic		Luther	WORK	CeL					Month	Da	4 200	4 2.40p
Examin		4a. Facility Name (If not institution				4b. City, Town,		of Death	. (40	County of D	
		Genesis Eldercare I		. Age (In yrs.	last birthdav)	Loch Rave		24 Hrs.	8. Date of Bi	rth	9. 1	Birthplace (State or Fore
ineral rector		217 01 9592	1□M 2□F	88	Yrs.	Months Day	s Hours	Min.	March 5	1916	Fa	quier Co., VA
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shov ad at	5		neo Citur		timore	Cation						1 € Yes 2 □
28a-1	rect	Maryland Baltimor	Le City	Date	ши	10f. Zip Code				10g. Ci	tizen of What	Country?
3a or		6413 Alta Avenue				21206			,	USA		
If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	11, Marital Status	12. Was Deced Armed Ford	ent Ever in U.	.S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Ori	igin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, W	merican Indian,
or it	y Fu	1 Never Married 2 Marri	ied 1 X Yes 2	. □ No		1 ☐ Yes 2 ☐ XN			,		Specify:	
al Ex	d be	3 Widowed 4 Divorced		es: W II	16a Dece	dent's Usual Occ	ination			16b K	(ind of Busine	White
"na" r	Completed	(Specify only highes	st grade completed)	45	(Give	kind of work don DO NOT use retii	e durina mos	st of worki	ing	100.1	and or basine	is a modelly
r than	mo	Elementary/Secondary (0-12)	College (1-4	40r 5+)	Superir	itement				Jew.	ish Cann	unity Center
arked other than atic event, IDE	Be C	17. Father's Name (First, Middle,		-			1		(First, Middle	, Maider	Sumame)	
arked atic e	10 6	Jessie F. Worre	1				Ethel	May V	Valler			
is m		19a. Informant's Name/Relationsh	_			ig Address <i>(Stree</i> 1ta <i>A</i> vanu					or Town, State 21206	e, <i>Zip Code)</i>
Important: It item 27 any injury or other tr once.		Matilda W. Worre	er	20b. P		sition (Name of	e Dei		e, Mary			or Town, State
or of		1 XBurial 2 ☐ Cremation		tate	emetery, crer	natory or other p	uly 19 2				imore, M	
njury		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service)	<u> </u>	Fall	kwood Ce					LXIIL	miore, r	ELYISIN
any ir		Mulmid	2000/10/10	mo		Name and Add SSAIN FUN				lend (21226	
		23a. Part1. Enter the disease, or	complications that cau	used the deat	h. Do not ent				ore, Mery		<u> </u>	Approximate
sician		shock, or heart failure. List Immediate Cause (Final	0	ch line.	1/20	11.10	. A	100	den	1-		Interval Between Onset and Deat
edical		disease or condition resulting in death)	a. Due to (o	r as a conseq	uence of):	Secure	/ / /				·	iles
miner												-
	e e	Sequentially list conditions	b									than &
#	드	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (o	r as a conseq							 	than &
and -transit	kamln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o		uence of):							than &
ician and burial-transit	al Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a conseq	uence of):							than 6
physician and s the burial-transit	dical	that initiated events	Due to (o		uence of):							than 6
nding physician and use as the burial-transit	dical	resulting in death) Last	Due to (o c	r as a conseq	uence of): uence of):						23d. Date of	
s attending physician and d for use as the burial-transit	dical	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or Due to (or d	r as a conseq ome of pregna th 2 □ Feta nt at time of d	uence of): uence of): ancy I death 3	Ectopic pregnan	су				23d. Date of Month	
by the attending physician and ached for use as the burial-transit	dical	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	C. Due to (or d. 23c. If yes, outcome to Live birth	r as a conseq ome of pregna th 2 □ Feta nt at time of d	uence of): uence of): ancy I death 3		су					delivery
gned by the attending physician and be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (o c	ras a conseq ome of pregna th 2 □ Feta nt at time of d	uence of): uence of): ancy I death 3 [eath 5 [Other (specify)		l.		tobacco	Month use contribute	delivery Day Year
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DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	•	epartment of Health and Certificate of Death		lene	23776
	Physici /Medi		1. Decedent's Name (First, Middle, Last, ELLA	WALK	ER	2. Date of Death	Day Yeer	3. Time of Death
	Examir	ner	5. Social Security Number 6. Sec	ins Hospital x 7. Age (In yrs. last birth	Months Dave Hours Mir	S. B. Dete of Birth (Month, Day,	Year) Coun	lece (State or Foreign
TATE	Director		220 36 2482 Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town		MARCH 4,		AROLINA Od. tnside City Limits
	r 28a-f eh	Funeral Director	MD N/A 10e. Street and Number	BALTIMO	RE 101. Zip Code	10	0g. Citizen of What Coun	1 X Yes 2 □ No
	ath with	ralD	1400 E. MADISON ST		21205		J.S.A	
980	be filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or Items 23e or 28e-f show event, the Mydical Examine must be rectified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 XNo Specify:	Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, of Specify:	etc.
1215-0	vithin 72 hours ne. han "natural", a Mudical Exa	Completed	15. Decedent's Edu (Specify only highest grad	(e completed) (Cottege (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of w ife. DO NOT use retired)	orking	16b. Kind of Business/Inc	lustry
Maryland 21215-0036	be filed ntal Hygi of other event, I	To Be Co	17. Father's Name (First, Middle, Last) FRANK WALKER	HEA	D PANTRY CHEF 18. Mother's No. MARGIE V	ame (First, Middle, N	MNI HOTEL Maiden Sumame)	
Baltimore, Maryl	permit. Pages 1 and 2 should be Department of Health and Mental Important: If I fem 27 is marked of any injury or other traumatic ev 0009.	Ţ	19a. Informant's Name/Relationship (Ty ROZINA BAGLEY (SIS) 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. No lature of Funeral Service License	TER) 380 Removal from State Mr. ZI	Mailing Address (Street and Number or F 7 ELKADER ROAD BALL Disposition (Name of crematory or other place) ON CEMETERY JULY 22. Name and Address of Facility	Rural Route Number, TIMCRE, MA Date 2 Y 30, 2004 CALVIN B.	RYLAND 2121 20c. Location - City or To 1 BALTO, MAR SCRUGGS FUN	8 wn, State RYLAND ERAL HOME
1000	Physician and wide price of partial transit the brital-transit the bri	l Examiner	23a. Pert 1. Enter the disease, or compleshook, or heart failure. List only or Immediate Cause (Finat disease or condition resulting in death) Coquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	LYMPHOCYTI C RESPIRATO	ac or respiratory arre	st,	TAND 21213 Approximate Interval Between Onset and Death MONTHS
O. Box 68760	death certifi e attending f d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	d. 3c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver	ry Day Year
rds, P.	The law requires that the tense been signed by this sage 2 should be detache	by	Part It. Dther significent conditions con	ntributing to death but not resulting in to	· · ·	23e. Did toba	acco use contribute to the	e cause of death?
Vital Records,		Completed				24a. Was an autopsy perform	prior to comed? death?	sy findings available ipletion of cause of
<u> </u>	ysicial is certification	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	fospitat: 1 X Inpatient 2 ☐ ER/Outp	0.4	eath Check on one Home 5 ☐ Resider	nce 6 Other (Specify,)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	atlon: T	27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury at	28d. Describe how		
N N	ital or Att irs after de ral Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town,	10.	
	To the Hosp within 24 hou To the Funel completely fil	Medical	one) 2 Medicel Exami	sician: To the best of my knowledge, oner: On the basis of examination and/ and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occurred as a second occurred to the control of the control occurred to the control occurred	surred at the time, dat	te and place, and due to	the cause(s)
	To wit	-	29b. Signature and title of certifier Chris Ong elimic 30. Name and address of person who co	MEDICAL DOCTOR			d. Date signed (Month, D	
70	Sta	te		O MEDICAL DOCT R 32. Registrar's Signature	JOHNS HOPKINS HO	SPITAL GOOM	crih wolfe sine	21287 FET, MARYLAND

	1	For State Registrar	State of M	laryland		artmen tificate			d Mental H	ygien Regin	001	1 2	237	77
Physician /Medica		1. Decedent's Name (First, Middle, Las MILDRED F'RAN	CES WALLA						2. Date of I Month July	D	ay 2004	Year	3. Time	of Death M
Examiner		sa. Facility Name (If not institution, give STELLA MARIS HO 5. Social Security Number 6. S	SPICE		ast birthday)		noniu	Location of D				alti	more	
Funeral Director	(087-30-4868 Usual Residence of Decedent		3	Yrs.	Months	Days		tin (Month, I	76, 1	911	New	York	e or Foreign
72 hours after death with the Maryland neturel; or items 23e or 28e-1 show after Examination at the result of the Arman Director	.	10a. State 10b. County Maryland Baltimor	'e	,	onium							1		City Limits es 2 💢 🎢 o
ufer death with the Ma r items 23e or 28e-fa ulter: ust be ricillied		10e. Street and Number 2300 Dulaney Vall	ey Road			10f. Zip	2109	93		10g. C	itizen of W USA	hat Cour	ntry?	
"neturel", or items	2	11. Marital Status 1 □ Never Married 2 □ Married XXWidowed 4 □ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 20 If Yes, Give Year or Dates:	? No		Was Deced fYes, spec 1 ☐ Yes 2		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	lo-		, White,	an Indian, etc. hite	
- 10		15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de co <i>mpleted)</i> College (1-4or	5+)		dent's Usua kind of wor DO NOT us memak	k done a e retired,	ition luring most of)	working	16b. I	Kind of Bus		dustry	
and Mental Hygiene. is marked other then eumetic event, IDE M. TO Be Comp.	3	17. Father's Name (First, Middle, Last) Harry George Preu	SS					Mae	Name <i>(First, Midd.</i> Duncan		n Sumame)		
em 27 is me ther treume		19a. Informant's Name/Relationship (1 Richard C Wallace 20a. Method of Disposition		on 20h Pi	19b. Mailir 1139 ace of Dispo	Dulan	ey c	and Number or Gate Ci	Rural Route Num	keys	or Town, S Ville Location - C	, Ma	rylan	030
Department of Health and Mental Hygiene. Importent: If item 27 is marked other then importent: If item 27 is marked other then any njury or other treumetic event, ID-8 Anoge. To Be Comp		1 \$\bar{\text{Burial}} 2 \subseteq Cremation 3 \subseteq \text{4 Donation} 5 \subseteq \text{Other} (Specify \\ \text{21 unature of Funeral Service Licen})	C6	metery, cren MAry ^I S	Ceme	tery:	7 7/ s of Facility	26/04 itchell-Wie	Ham:	ilton d Fune	, Ne ral H	w Jer Iome Ir	1C
nysician Medical xaminer		23a. Part1. Enter the disease of companions, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a Due to (or as	3 a consequ	encoon:	mye	P-	, such as card	York Road E	arrest,	ore, M	aryla	Approxim Interval B Onset and	ate etween
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cate has been signe page 2 should be c									24a. Wa auto peri 1 🗆 Yes	s an opsy ormed? 2 2 40	pri de	or to con ath?	osy finding apletion of 2 \(\text{No} \)	s available cause of
ath. r: After this certificate has funeral director, page after the To Be Com		27. Manner of Death 1 Neural 5 Pending 2 Accident investigation	-		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r. 4 Jursing	Death (Check only g Home 5 \sum Res 28d. Describe	idence)	
within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director. Medical Certification: To Be C		3 Suicide 6 Could not be determined	building, e	tc. (Specify,)				28f. Location City or To	wn, State	е)			mber,
thin 24 hour of the Funer ompletely fill		29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best liner: On the basis o and manner si	of examinati	vledge, death ion and/or inv	occurred a estigation,	it the time in my op	e, date and pla inion, death oc	ace, and due to the courred at the time	cause(s , date an) and mani d place, an	ner as sta d due to	ited. the cause	(s)
		29b. Signature of title of certifier	14/2	do	7	29c.	License	number 155	N	29d. Da	te signed (Month, E	Day, Year)	
3		30. Name and address of person who of Eddie Nakaida, M				,	Road	l, Timo	nium, Ma	ryla	nd 21	093		
State Registrar		31. Date filed (Month, Day, Year)	32. Regist	rar's Signati	urg	box				-				

ORIGINAL

			1 - For State Registrar	State of M	arylan		artmen rtificat			and M	ental H	ygien	1001	23778		
			1. Decedent's Name (First, Middle, Last)						-	2. Date of I		ay Yea	3. Time of Death		
	Physici /Medic		Sophie Wask	iewicz							July 2		2004	7:15 A M		
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death		4	ic. County of De	ath		
в			Quail Run Assiste	d Living				ry H					Baltimo:	re		
24	Funeral Director		213-12-0483	x 7. Ag ☐ M 21K☐ F	e (In yrs. 89	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of E (Month, I	Birth Day, Yee 27, 19	9. B 914 Mar	irthplece (State or Foreign Country) Cyland		
	D .		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits		
	a-f shor	ctor	Maryland N/	A	100.01	y, rown or Lo		timo	re					1 ∰Yes 2 ☐ No		
	1 th	Jire	10e. Street and Number				10f. Zip	Code				10g. C	Citizen of What	Country?		
	23a	aic	3504 Northway Dri	ve			2	1234				U.S	5.A.			
21215-0036	be filed within 72 hours after death with the Maryland stal Hyglene. Id other than "natural", or Itams 23a or 28a-f show event, tra Mudical Exacting filest at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Stif Yes, Give Year or Dates:			Was Deced If Yes, spec 1 ☐ Yes		spanic Origin, Mexican Specity:	gin? (Spe i, Puerto f	cify Yes or I Rican, etc.)	No-	14. Race - Ar Black, Wi Specify: W			
Ö	2 hou	ted	15. Decedent's Edu			16a. Dece	dent's Usua	at Occupa	tion			16b.	Kind of Busines	ss/Industry		
215	hin 7	pie	(Specify only highest grad	College (1-4or:	5+1	life.	kind of wo DO NOT u	nk done d se retired	luring mosi)	t of workir	ng	Μe	edal Gol	Ld		
21	filed withi Hygiene. ither ther	Completed	Elementary, coolingry (5 12)	00110g0 (1 401 1	J.,	Fac	tory	Work	er			Ic	ce Cream Factory			
b	should be filed within nd Mental Hygiene. marked other than imatic event, it a Mi	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Midd	le, Maide	an Surname)			
lar	Aenta Aenta	ToE	Anthony Rykoski		Juliana Sp						a Spar	parzak				
Maryland	od 2 lith ar 27 Is 1 trau		19a. Informant's Name/Relationship (7) Anthony Waskiewcz				-						or Town, State ryland			
ē,	of Health Item 27 other tr		20a. Method of Disposition			Place of Dispo	sition (Nar	ne of	a)	D	ate	20c.	Location - City	or Town, State		
Baltimore,	permit. Pages Department of I Important: If Its any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)				-		-	uly 2	26,200	4Bal	timore,	Maryland		
alti	artm Sorta		21. Sign ture o Funeral Service Licens		-								Funera			
ñ	Depa Impo any ii		Vale 17	Part									aryland			
21	Physician /Medical Examiner	ner	23a. Parti [§] Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death) Sequentiatly list conditions, if any, leading to immediate	ications that cause on each line cause on each line. Due to (or as Due to (or a) Due	d the death	uence of):	er the mod	le of dying	g, such as	cardiac or	r respiratory	arrest,		Approximate Interval Between Onset and Death		
	be executed sician and burial-transif	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. DEM Due to (or as	E/S/	uence of):										
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. Box	that the death certificate be executed that the attending physician and detached for use as the burial transif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	Ectopic pi						23d. Date of d Month	elivery Day Year		
ds, P	ires that signed t d be det	by	Part II. Other significant conditions co	ntributing to death b	out not res	ulting in the u	nderlying o	ause give	n in Part I.			tobacco		to the cause of death?		
Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed									24a. Wa	is an opsy formed?	/ death?			
		ပိ	25. Was case referred to medical						00 81	-4.0	1 Yes		6 1 □ Ye	es 20 No		
₹		00	eyaminer?	Hospital:		ED/Output	, aC D	Othe			(Check only		-			
o	Phys r this rai di	. To	27. Manny of Death			ER/Outpatier 28b. Time of				_	ne 5 Re		occurred	эөспу)		
on	ding h. h. After funer	tior	1 atural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ıý Yəər)	Intury	м	8c. Injury Work	:? /es 2 □ l				,			
Division	or Attending after death. Director: After in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At ho tc. (Specif	ome, farm, str	eet, factor					(Street a		Rural Route Number,		
_	ospital hours uneral ly filled	Medical Co	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best iner: On the basis of and manner st	of examina	wiedge, deati	n occurred vestigation	at the tim	e, date an	d place, a th occurre	nd due to the	e cause(e, date ar	s) and manner and place, and di	as stated. ue to the cause(s)		
	To the Hi within 24 To the Fi complete	Me	29b. Signature and titte of certifier	a a mailioi st			290	c. License	number			29d. D	ate signed (Moi	nth, Day, Year)		
	F 3 F 8) (airin)	1.	11-		2	N	774	8		7	122/	14		
•	1		XUM MORE	16 /4	CHA	1//	Painm	1/2	-/ 5	2		-/	1-70	/		
	9		30. Name and address of person who c	ompleted cause of	Jeath (tten	7 M	in by	A	16	V	Dien	AM	W AM	2/777		
	Sta	ato.	31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	iture	1/50	-1	1 / 7	T /	141/0		- 17D	1/221		
	Registi		1111 9 9 2004	Real	H	Real	Al a									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Mary		artment of H			giene Rag. No. 0 ()		23779
	rsicia	n	1. Decedent's Name (First, Middle, Last) Calvert Stanley	Ziegler,	Jr.		7-	2. Date of Dea July 2	ath	Year 1	3. Time of Death 7:30A M
1	ledica amine	r	4a. Facility Name (If not institution, give s 321 Whitelock St	treet and number)		4b. City, Town, or Baltin			4c. County		
Fune Direc		-	1 1330	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, 1993	Cour	place (State or Foreign htry) y land
faryland			Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo						0d. Inside City Limits ↓□ Yes 2 □ No
with tha N		Direct	Maryland N/A 10e. Street and Number 1252 Carroll St	reet	Balti	10f. Zip Code 21230	· · · · · · · · · · · · · · · · · · ·		10g. Citizen of V	Vhat Cour	
Nnd 21215-0036 be filed within 72 hours after death with the Maryland hal Hygiene. hat Hygiene. ratural, or itema 23a or 28s-1 ehow about		by Funeral Director		12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give			spanic Origin? (Specify Yes or No-	14. Race	k, White,	ean Indian, etc.
21215-0036 d within 72 hours af gjene. or than "natural", or	medical E	Completed	15. Decedent's Educ (Specify only highest grade	Year or Dates: cation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of w	orking .	16b. Kind of Bu		
ba filed tal Hygi		10 Be Cor	5th grade 17. Father's Name (First, Middle, Last) Calvert S. Zieg		ame (First, Middle, a Smith	Maiden Sumam	Θ)				
≥ ₽ ₹ 5 €			19a. Informant's Name/Relationship (Type Nina Smith/Moth	er	1252	2 Carrol		Rural Route Numbe et Balt	imore,	Mar	yland
Baltimore, bermit. Pages 1 a Department of Hee mportant: If Item	io io dent	4	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		n Cemet	1			ore,	Maryland
Balt permit. Departr Imports	Suce		21. Signature of Funeral Service Usense 23a. Part. Enter the disease, or compli	L	52	240 Reis	tersto	wn Road	Balti		al Home e, Md 212
(6U, be executed Sician and burial-transit	cal ner	Adminet	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of sequence of	elmon L po		arres	t		Approximate Interval Between Onset and Death
the death certificate by the attending physached for use as the		Ilysiciai i/Medicai	in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	egnancy Fetal death 3 [of death 5 [Ectopic pregnancy Other (specify)			23d. Date Mon	th	Day Year
Tecords, The law requires that te has been signed to age 2 should be detailed.	yd bot	2	Part II. Dther significant conditions con	nbuting to death but not	resulting in the ur	nderlying cause give	n in Part I.				e cause of death? ably 4 □Unknown
	and a		25. Was case referred to medical					24a. Was a autops perform	production of the production o	/ere autor rior to con eath? Yes	osy findings available npletion of cause of
n OT ng Phy fter this		2	examiner? 1	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing I	eth Check onl on Home 5 Reside 28d. Describe ho	ence 6 the	r <i>(Specify</i> ed)
LIVISION Ital or Attending Its effer death. al Director: Affe	Cortification		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre ecify)	eet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	r or Rural	Route Number,
To the Hospital or within 24 hours effer To the Funeral Direction completely filled in billing in b	Modical	בפונים 	one) 2 Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	nination and/or inv	estigation, in my op	inion, death occ	urred at the time, da	ate and place, ar	nd due to	the cause(s)
To To	3	4	· Rau	har 1	M)	29c. License	13970)	9d. Date signed		Day, Year) - 2004
7			1501 PIVISION		Balti	Print) More	MO S	11217			
	State istrar		31. Date filed (Month, Day, Year) JUL 2 8 20(32. Registrar's Si	gnature	doar					

DHMH 16 Rev 6/95

Registrar

ELIAS S. ADAMOPOULOS

			Please 1	Type or Prin State of Ma		Depa	artment	of H	ealth a	and M	-	ygier	ne	
			Registrer 1. Decedent's Name (First, Middle, Last)		Cei	tificate	of L	Death		2. Date of D	Reg. I	No? () () (;	2378
	Physic /Medi Examii	cal	Elias Stavr. 4a. Facility Name (If not institution, give		damopo	ulos	4b. City, 1	Fown, or	Location	of Death	JULY		7, 2004	4:25 PM
	LAUIIII	iÇ.	Salisbury Nursing				W.11=1-				y, Md.		Wicomico	
	Funeral Director		5. Social Security Number 6. Se 212–44–9816 Usual Residence of Decedent	x 7. Age	e (In yrs. last 72	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, L April	Day, Yea	ar) Coi	pplace (State or Fore untry) ACUS, Gree
	e Maryland sa-f show	ctor	10a. State 10b. County Maryland Wicomico	,	10c. City, To		cation							10d. Inside City Lim 1 ☐ Yes 2X
	with th	Director	10e. Street and Number				10f. Zip	Code				10g.	Citizen of What Cou	intry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygene. I Health and Menial Hygene. item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, if a Maxical Exactle art and item inclined at	by Funeral	501 Tony Tank Lane 11. Marital Status 1 Never Married 2 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give		1	2180 Was Decede f Yes, speci I □ Yes 2	ent of Hi ify Cuba	spanic Ori n, Mexicar Specify:	gin? (Spo n, Puerto	ecify Yes or N Rican, etc.)	lo-	14. Race - Amer Black, White	, etc.
5-0036	2 hours		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16	Sa. Deced	lent's Usual	I Occupa	ıtion			16b	Kind of Business/I	White
21215	ad within 72 giene. er than "na	Completed	(Specify only highest grad	e co <i>mpleted)</i> College (1-4or 5	i+)	(Give life. l hysi	kind of worl DO NOT use	k done d e retired	lu <i>ring m</i> os)	t of work	ing		Medio	,
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, II s.M.	To Be	17. Father's Name (First, Middle, Last) Stavros ——	Adamo	poulos					er's Name iliki	e (First, Middl i	e, Maid	,	.iveras
Var	12 sho		19a. Informant's Name/Relationship (T)										y or Town, State, Z	
	ges 1 and to of Health If item 27 or other tr		Stella Latsios Ada	mopoulos	20b. Place	of Dispo	sition (Nam	e of			Salisbu Date	_	Maryland Location - City or 1	
mor	Φ ° == =		1 Burial 2 Cremation 3 □F 4 □Donation 5 □ Other (Specify)	Removal from State	ceme	tery, cren	natory`or ott morial	her place	1					
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licental Country Coun	orenes (CFSP	22 H	Name and	Addres	s of Facilit	il Ho	ome Pro	ofes	lisbury, sional As y, Maryla	sociation
	Hrysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complished, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to him collaborations.	Due to (or as a Due to (or a) Due to (a consequence	ce of):	Ce solve the mode	of dying	g, such as	cardiac c	or respiratory	arrest,		Approximate Interval Between Onset and Death
68760,	certificate be executed Iding physician and Ise as the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequenc	ce of):						_		
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rds, P	ires sign d be	by	Part II. Other significant conditions con	ntributing to death bu	ut not resulting	j in the ur	nderlying ca	use give	n in Part I.				use contribute to	the cause of death?
Record		Completed								_		s an opsy ormed	prior to co	opsy findings availat empletion of cause o
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		-		Othe			Check onl			
ō	ing After une	tion: To	1 Yes 2 No 27. Manner of Death 1 Yatural 5 Pending 2 Accident investigation	1 ☐ Inpaties 28a. Date of Injur (Month, Day	nt 2□ER/0 y Year) 28b	Outpatient Time of Injury		c. Injury Work	4 Nu	1	me 5 ☐ Res 28d. Describ <i>e</i>		6 □Other (Speci jury occurred	fy)
Division	i Qitte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuling, etc.	Iry - At home, c. (Specify)	farm, stre	eet, factory,	office		1	28f. Location City or To	(Street a	and Number or Run ite)	al Route Number,
	To the Hospital within 24 hours a To the Funeral E completely filled i	edicai	one)	sicien: To the best of ner: On the basis of and manner sta	examination a	lge, death and/or inv	occurred a estigation, i	t the tim in my op	e, date an inion, deal	d place, a	and due to the ed at the time	cause((s) and manner as s nd place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier					_	number	>	0	29d. D	ate signed (Month,	Day, Year)
•			1000 100-c	~	0.75			12	1	4	7		18/04	
DC	Sta	to.	30. Name and address of person who co	obius,	eath (Item 23a)	1346			on S	St.Suit	e,S	alisbury,	Md.21804
	Registi		JUL 0 9 201	14 Sens	مقسم	٦	Spo	uks						

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma		artment of Health and rtificate of Death		ene	23782
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, La May 1 e 4a. Facility Name (If not institution, gives 1252 Crowell Co	A B e street and number)	aner	4b. City, Town, or Location of De	2. Date of Death Month O'7	Day Year 10 2004 4c. County of Death	3. Time of Death 4:02 p ^M Arundel
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday) 72 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		Year) 9. Birthpl	lace (State or Foreign try) MD
	e Maryland ta-f show	ctor	10a. State 10b. County	Arundel	10c. City, Town or Lo	Arnold		10	0d. Inside City Limits 1 ☐ Yes 2 No
	3e or 28	I Dire	10e. Street and Number 1252 Crowell Co	urt		10f. Zip Code 21012	10	og. Citizen of What Coun USA	try?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 le marked other then "naturel", or iteme 23e or 28a-f show other traumatic event, the Mudical Experiment, use the profilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	,	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, o Specify:	
21215-0036	filed within 72 hi Hygiene. other then "natu ent, the Madical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired) Receptionist	vorking 1	6b. Kind of Business/Ind Weight Wa	
Maryland	should be filed and Menta! Hygid le marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last Arthur E. Duff				lame (First, Middle, M Cllen McLau		
	nd 2 shoulth and 27 le mur		19a. Informant's Name/Relationship (Mary C. Tempesti	**		ing Address <i>(Street and Number or</i> 52 Crowell Court			Code)
altimore,	eg = 5		20a. Method of Disposition 1 XBurial 2 Cremation 3 C 4 Donation 5 Other (Special			osition (Name of matory or other place) dge Mem. Pk.	lv 16.	eoc. Location - City or To	
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Suneral Service Lice	Allen	B 4	2. Name and Address of Facility arranco & Sons, 95 Gov. Ritchie	P.A. Sever Hwy, Sever	na Park Fur na Park, M	eral Home 21146
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused to one cause on each line a. Metasta Due to (or as a). -	ter the mode of dying, such as card	1.		Approximate Interval Between Onset and Death
, ,		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):				
P.O. Box 68760,	The law requires that the death certificate be executed te has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12,months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	⊒Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
	quires that on signed b uld be deta	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	underlying cause given in Part I,	23e. Did tob	acco use contribute to th s 2 X No 3 ☐ Proba	e cause of death?
Vital Records,	ig 🗠	Completed					24a. Was an autopsy perform	prior to con led? death?	psy findings available inpletion of cause of
Vita	Physicien: Th r this certificate ral director, pag	o Be (25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie	Other	eath (Check only one	nce 6 Other (Specify	4)
ion of	Jing After fune	H-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time o		28d. Describe how		7
Division	in Die	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural , State)	Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best of miner: On the basis of each manner state	examination and/or in	th occurred at the time, date and pla nvestigation, in my opinion, death oc	ice, and due to the car curred at the time, da	use(s) and manner as sta te and place, and due to	ated. the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier	eg MD)	29c. License number	- 3	7 -12 -04	Day, Year)
			30. Name and address of person who Kath Leen Ke	completed cause of de	ath (Item 23a) (Type	DOOS917 Print) Hate Rd, Swil	te 300,	Annapoli.	s, MD
	Sta Regist		31. Date filed (Month, Day, Year) JUL 1 6 2	32 Jegistrar	's Signature	and a		•	2140/

State of Maryland / Department of Health and Mental Hygiene Reg. Ng. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month **Physician** 4:00 p M 2004 Mary Virginia Bitner July 17 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Western Maryland Hospital Center Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F 75 216-22-1737 Aug. 23,1928 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Itams 23a 21315 Leiter Street 21742 USA death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene.
snt: if Item 27 is marked other then "netural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Owner-operator Restaurant 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Chester E. Harley Pearl E. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn V. Lewis/Daughter 13340 Unger Road, Hagerstown, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if eny injury or once. Rest Haven Cemetery 7/20/2004 Hagerstown, Maryland ⁴ □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Avenue, Hagerstown, Md. 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Pulma **Physician** e min resulting in death) /Medical Due to (or as a consequence of): Examiner Rend Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in thiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed Diabety Mallita Due to (or as a consequence of): Box 68760 the attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached Records, P.O. 9 Unknown 9 Duknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 **J-No** Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: after death. Director: After 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number P1081 Q JULY 17. 2004 CM THES 1500 Pennsylvania Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO DATTA Hagerstown, MD 21742 31. Date filed (Month, DM Year 9 2004 32. Resistrar's Signature) State Registrar

			1 _ For		/ Dep	artment of H	Health and M	lental Hygi	ene	Die.				
			Registrar	A1	Ce	uncate of	Deam		g. No) 4	23786			
	Physici	an	1. Decedent's Name (First, Middle, Last					Month	Day	Year	3. Time of Death			
	/Medic		Kenneth Micha		•			July 14	, 2004		2:31 A. M			
	Examin		4a. Facility Name (If not institution, give	Bassard, Jr. July 14, 2004 2:31 A										
			The Johns Hopkin	s Hospital		Baltim	ore							
	Funeral		5. Social Security Number 6. Se		• • •			8. Date of Birth	rear)	9. Birthp	place (State or Foreign			
	Director			XX 20 23	Yrs.									
	P .		Usual Residence of Decedent	10- Cit. 7										
	shov	-	10a. State 10b. County							,	•			
	Ba-f	cto	Maryland Prince	George's	Clin	ton					XX			
	라 다 0 2 2	Olre	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	What Cour	ntry?			
	1th w 230	Funeral Director	5211 \$	Sumter Court			20735		Uni	ted :	States			
	ems erra	ne	11. Marital Status	 Was Decedent Ever in U.S. Armed Forces? 	13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Bican, etc.)	14. Rac	e - Americ	an Indian,			
9	afte or it	Ŧ	XX Never Married 2☐ Married	1 ∐ Yes 21√TNO	i			, , , , ,						
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:			opodily.		Зреспу	.]	Black			
5	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than 'natural', or items 23e or 28e-f show imatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ucation 1 de completed)	6a. Dece	dent's Usual Occup	ation during most of work	ing 1	6b. Kind of Bu	usiness/In	dustry			
2	ithin Ne.	ldu	Elementary/Secondary (0-12)		life.	DO NOT use retire	d)							
Maryland 21215-0036	filed withi Hygiene. Ither than	ပ်	12	4	Stud	ent								
p	al H d oth	Be	17. Father's Name (First, Middle, Last)						aiden Sumam	10)				
<u> a</u>	should be nd Mental marked o	^o	Kenneth M. Bassa	ird			Mary B.	White						
a	2 should be fi n and Mental H Is marked ot reumatic ever		19a. Informant's Name/Relationship (7)	ype, Print)										
	of Health of Health item 27 I		kenneth M. bassar		521	1 Sumter	Court, C1	inton, M	arylan	d 207	735			
Z	nit. Pages 1 and 2 should artment of Health and Mer ortent: If item 27 Is marke injury or other treumatic g.		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of natory or other place	ce). July 19	200/i	c. Location -	City or To	wn, State			
Baltimore,	permit. Pages Department of I Important: If it any injury or o	1 A Donation 5 Other (Specify) 1 A Donation 5 Other (Specify) 1 Resurrection Cemetery Clinton												
₩	permit. Pag Department Important: I any injury o													
m	Depar Depar Impor any ir	. 4	KeOQ KHa	the mo 1190	Ø A	lexandria	Ferry Rd	Clinto	n Mar	v1 and	20725			
	-		23a. Part1. Enter the disease, or comp	lications that caused the death. [Do not ent	er the mode of dyir	ng, such as cardiac of	or respiratory arres	t,	yrand	Approximate			
	Dharisian		shock, or heart failure. List only of Immediate Cause (Final								Interval Between Onset and Death			
7	Physician /Medical		disease or condition resulting in death) a											
	Examiner					occion								
	. %	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			581011					3 Months			
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury	Bone M	arro	Tranc 1	ant				0.14			
	al-tra	xa	resulting in death) Last			· IIdiis I	ant				3 Months			
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687	ficate phy s the			0		<i>y p o c</i>					ı iear			
×	leath certificat attending phy I for use as th	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy	,				22d Det	a of dalisa				
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?				′				•			
o.	at the de by the a tached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown			Caror (apoony)								
0	that ed by deta		Part II. Other significant conditions co	ntributing to death but not resulting	ng in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contr	ibute to th	e cause of death?			
ds	sign d be	d by	Thrombocytopenia					1 ☐ Yes	2 📆 N/o	3 ☐ Proba	ably 4 Dünknown			
Ö	w requir been si should I	ete												
Records,	8 2 2	ompleted						autopsy	p	rior to con	osy findings available apletion of cause of			
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Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	domital										
of	Phys this al dir	2	I Les SXX	1 Light 2 LER	-	t 3 DOA	er: 4 ☐ Nursing Hor)			
<u></u>	ding f h. After funer	on	27. Manner of Death 1 XX atural 5 ☐ Pending	(Month, Day Year)		Wor	k?	28d. Describe how	injury occurre	ed				
Sic	Attending ir death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be											
Division	after death after death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office	1	28t. Location (Stre City or Town,	et and Numbe State)	er or Rurai	Route Number,			
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	To the Hospital or within 24 hours after To the Funeral Directory completely filled in b	edical	(Check only 2 Medical Exami	ner: On the basis of examination	dge, death and/or in	occurred at the ting restigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, date	se(s) and mai and place, a	nner as sta	ated. the cause(s)			
	tha hin 2 the nplei	Med	one)	and manner stated.										
	T wit	-	29b. Signature and title of certifier	Manna 12	MI				-		* * * * * * * * * * * * * * * * * * * *			
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F	122		30. Name and address of person who co											
1	ノシン		Emily Schopick	, MD 600 North	Wolfe	Street,	Baltimor	e, Maryla	and 212	287				
	Sta Registr		31. Date filed (Month, Day, Year) 21	32. Registrar's Signature	R A	rest 1								
		-11	U	-	11	Mr. White.								

			1 - For State Registrar	State o	f Ma	ryland / De	partmer ertificat				lental Hy	ygiene Reg. Ne	2001	A	23785
	Physici	an.	1. Decedent's Name (First, Middle,	Last)				-			2. Date of D Month	eath Da	v Ye	ar	3. Time of Death
9	/Medic	al	George William			•					July	11,	2004	4	10:50 P.M
Ĭ.	Examin	ier	4a. Fecility Name (If not institution, g	give street and nu	mber)			lown, or uitl	Location of	of Death			County of E		
	Funeral		313 Holiday St. 5. Social Security Number 6	. Sex	7. Age	(In yrs. last birthd	y) If Under	1 Year	If Under		8. Date of B	irth	Vicomio 9.		ace (State or Foreign
	Director		213-34-5170	1 🕅 M 2 🗆 F	67	Yrs	. Months	Days	Hours	Min.	2-13-1	a <i>y, Year)</i> L937	,	Counti	ace (State or Foreign ny) Md.
	pur *		Usual Residence of Decedent 10a. State 10b. County			10c. City, Town o	Location								d. Inside City Limits
	Maryia f • ho	ō		ino		Fruitla								10	1X□Yes 2□No
	r 28e-	Director	Md. Wicom 10e. Street and Number	100		FIGICIA	10f. Zip	Code				10g. Ci	tizen of What	t Counti	ry?
	th with	alD	313 Holiday St.				21	.826				US	5A		
	r dee	Funeral	11. Marital Status	12. Was Dec Armed Fo	rces?		3. Was Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or N Rican, etc.)	0-	14. Race - A Black, W		
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215	thin 7:	Completed	(Specify only highest Elementary/Secondary (0-12)	luring mosi)	t of worki	ng				,					
7	filed wil Hygien other the		12	College (erviso	=				1	oncret	e	
		Be	17. Father's Name (First, Middle, La George Butera	ist)							(First, Middle		ŕ		
<u> </u>	should nd Me mark matic	မှ	19a. Informant's Name/Relationship	(Type, Print)		19b. M	ailing Address	(Street a			nn Care			te Zin C	Code)
<u>8</u>	nd 2 saith ar 27 te r trau		Norma L. Butera,			313					tland,			. O, ZIP C	,000
Ē,	of Hee item item		20a. Method of Disposition			20b. Place of Discemetery, of				_	ate		ocation - City	or Tow	n, State
Ĕ	Page nent cannot		1)☐ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe		State	Mt. Ple			1	-16-0	04	Will	lards,	Md.	
Balt	permit. Pages 1 and 2 should be Deperment of Health and Menta Important: If item 27 is marked eny injury or other traumatic events.		21. Signature of Funeral Service Lic	censee			22. Name ar Short	d Addres	s of Facility	y Home	. Inc.				
	0 0 F ● 0	11 0	200 Part Fatality Fatality		,	She david David	13 E.	Grov	ze St	. De	Lmar, 1	De. 1	19940		
	SET - 1		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	~ 1			,			,			1.		Approximate nterval Between Onset and Death
į.	/Medical		disease or condition resulting in death)	a. Ch	0	consequence of):	591v	cti	ver)uli	nona.	MY	Jis ea	50	
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Box	S dir	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come o		3 □Ectopic pr	000000					23d. Date of	delivery	
	8 9 B	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at t		5 Other (sp						Month	D	ay Year
J.	The law requires that the de ste hes been signed by the e page 2 shouid be detached	Phy	9 ☐ Unknown Part II. Other significant conditions			t aat sooulting in the			n in Dant	_	22a Dist	•====		- 1- 1-	cause of death?
Š,	ires that signed t d be det	d b	Part II. Other significant conditions	contributing to d	Balli Du	triotresuming in the	underlying c	ause give	m m rant.			Yes 2		e to the Probab	
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		BeC	25. Was case referred to medical	T					26. Place	of Death	1 ☐ Yes (Check only		1114	es 2	∐ No
> to	8 .g =	다 면	examiner? 1 Yes 2 No	Hospital: 1 🗆	npatien	t 2 ER/Outpat	ient 3 DC	A Othe			ne 5 🖢 Resi		6 □Other (S	pecity)	
č	ding Ph h. After th funerei		27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury th, Day	Year) 28b. Time Injur	/	8c. Injury Work	?		8d. Describe	how injur	y occurred		
Division	ir Attendi ter death. irector: A ir by the fu	Icat	2 Accident investigat 3 Suicide 6 Could not	be as Place	of Injur	y - At home, farm,	M street factor		es 2 □ N	_	Rf Location /	Street an	d Number or	- Dural C	Route Number,
<u>≥</u>	after of Direct of in by	Certification;	4 ☐ Homicide determine	buildi	ng, etc.	(Specify)	Stiest, lactory	, onice		"	City or To	wn, State)	nurarr	loute ivaliber,
	To the Hospitel or within 24 hours afte To the Funeral Discompletely filled in		29a. Certifier 1 Certifying I	Physician: To the	best of	my knowledge, de	ath occurred	at the time	e, date and	place, a	nd due to the	cause(s)	and manner	as state	ed.
	the Ho in 24 the Fu	Medical	one) 2 Medical Ex	aminer: On the b	asis of 6	examination and/or ed.				h occurre	d at the time,	date and	f place, and d	due to th	ne cause(s)
	To the within To the comple	2	29b. Signature and title of certifler				290	. License		Э		29d. Dat	te signed (Ma	onth, Da	ly, Year)
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2		1	30. Name and add of person who DR FRANK ARENA!	completed caus	eb 10 e	ath (Item 23a) (Typ	e, Print)	17	5 n 4						
Ì	Sta	te	31. Date filed (Month, Day, Year)		egistrar	's Signature	E I	pork	100						
41	Registr	ar	JUL 13	2004	Der	m /	14	, our							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year July **Physician** 2004 1015 /Medical Angel Conty 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 € M 2 □ F Director 120-24-9196 September 3, 1924 Puerto Rico Usual Residence of Deceden deeth with the Maryland 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits r then "naturel", or Items 23e or 28a-f show the Medical Examiner must be notified at 1 @Yes 2 □ No Funeral Director Puerto Rico Aguavilla 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 Urb Marbella 00603 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other then "naturel", or Iten eny injury or other treumetic event, Ite Mcdical Examiner once. Yes 2 No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1948–1969 1 Yes 2 No Specify. ⋧ 3 ☐ Widowed 4 ☐ Divorced Puerto Rican white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ counselor high school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Geraldo Conty Ana Nieves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Conty/ wife C St. 120 Urb. Marbella Aguavilla, PR 00603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Monte Cristo Memorial July 17, 2004 agreed and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Jarrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Box 68760 Physiclan/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an ,24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy certificate 1 ☐ Yes 2 No Division of Vital the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Dinpatient 2 ER/Outpatient 3 DOA this 27. Mannet of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 | Hatural 5 Pending after death. investigation 1 Tes 2 Accident 6 Could not be determined 3 🗒 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours after within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicef Exeminer. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed, (Month, Day, Year) 29b. Signature and 0 31. Date filed (Month 32. State Registrar

		1 - For State Ragistrar	State of Marylan	-		f Health and of Death		leg. No.	0001	23.7	8.7
Physicia /Medic	al	Decedent's Name (First, Middle, Last, Clifford 4a. Facility Name (If not institution, give)		C1	ine	m, or Location of Deat	July 9	Day	Year 2004 County of Death	9:22	A M
Examin Funeral Director	er	6603 Magnolia Terr 5. Social Security Number 6. Sec. 10	ace	<i>last birthday)</i> Yrs.	Lanhai	m	8. Date of Birth	Year)	Prince C	place (State o	
72 hours after death with the Maryland natural', or tlems 23e or 28a-f show dical Examiner must be coulled at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		y, Town or Lo 1ham	cation					0d. Inside Cit	
th with th	Funeral Director	10e. Street and Number 6603 Magnolia Teri	ace		10f. Zip Coo 20	706	. 1		S.A.	ntry?	
urs after dea at', or ttems	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ₩ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1945-		Was Decedent f Yes, specify (1 ☐ Yes 2 ☐	of Hispanic Origin? (S Cuban, Mexican, Puer No <i>Specify:</i>	Specify Yes or No- to Rican, etc.)		14. Race - Americ Black, White, Specify:		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tha Madical Examinational De notified at once.	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give life. L	dent's Usual Ookind of work do	one during most of wo stired)	rking		nd of Business/Inc Partment Navy	of	
About the filed Mental Hyginarked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Glenn Algie	Cline			18. Mother's Nai	me (First, Middle, Therese	е	Sumame) Husemo11	.er	
and 2 she raith and 1.27 is my er traums		19a. Informant's Name/Relationship (Ty Alan Cline/ Son	pe, Print)		-			ute Number, City or Town, State, Zip Code) i.e., Maryland 20720			
iit. Pages 1 artment of He artment of He ortant: If item injury or other	- 1	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	temoval from State	emetery, cren intt Cr	sition (Name of natory or other emator) Name and Ad	place)	yland				
Depa Impo any ii	1	> Kell		16	000 Anı	napolis Ro	ad, Bowie	e, M		20715	
Pnysician /Medical Examiner			ne cause on each line. Prosta Due to (or as a conseq	ate Can		5) ii g	o o i i copriatory an	001,		Approximate Interval Bett Onset and D	ween Death
death certificate be executed in a strending physician and et for use as the burial-transit	icai Examiner	if any, leading to immediate cause. Enter Underlying Cause. One sace of high that initiated events resulting in death) Last	Due to (or as a conseq Due to (or as a conseq								
death certiff e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregna Other (specify			4	23d. Date of delive Month	-	/ear
sign d be	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the ur	nderlying cause	given in Part I.	T	baccou es 2[se contribute to th XNo 3 ☐ Prob	ne cause of di ably 4 □U	
ate h	Completed						24a. Was a autops perfori		death?	psy findings a npletion of ca 2 No	
Physician: I rthis certifical ral director, p	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA	26. Place of Dea Other: 4 Nursing H	ath <i>(Check only on</i> Home 5 XX Reside		6 □Other (Specifi	()	
tending leath. tor: After the fune	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 2 Noticited Security Secu								y occurred d Number or Rura		ber,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Cert	29a. Certifier 17 Certifying Phy (Check only 2 Madical Exami	building, etc. (Specification) sician: To the best of my knowner: On the basis of examina	wledge, death	occurred at th	e time, date and place	city or Town	ause(s)	and manner as st	ated.	
o the l	Med	29b. Signature and title of certifier	and manner stated.			ense number			e signed (Month,		
r s r o		Jam J.	Hame	~ M	C.	3829	The state of the s	Ju1	y 9, 200	4	
Sta Registr		Kevin J. Shannon,		eenway		r Drive, 20	05, Green	bel	t, Maryl	and 20	7.70

			For State	State of M	laryland /		artment of F		nd Mei			01	A 17 m	
			Registrar 1. Decedent's Name (First, Midd)	le (ast)		Cel	lilicate of	Dealii	2.	Date of Dea	Reg. No.		3. Time of	f Death
40	Physici /Medic		CARL	ELLSW	ORTH	CL	INEDINST		·	Month July	2 200	Year 4	12:2	5 PM
1	Examir		4a. Facility Name (If not institution)		4b. City, Town, o		Death			ty of Dea		
36			Wicomico Nur 5. Social Security Number		ge (In yrs. last b	inth da l	Salis If Under 1 Year		4 Hrs la	Date of Birt		comi		
b	Funeral Director		212-18-2565	6. Sex 7. A	82	Yrs.	Months Days	Hours	Min.	(Month, Day	, Year) 1922	M. M.	thplace (State ountry) ARYLAND	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	/	10c. City, To	wn or Lo	ocation						10d. Inside C	ity Limits
	Marylan f show	ţō	DELAWARE SUSS	SEX	SEI	JBYV	ILLE						1 ☐ Yes	2₹ No
	or 28a	Director	10e. Street and Number				10f. Zip Code				10g. Citizen o	f What Co	ountry?	
	23a c		19 G BLUE BI	LL DRIVE			199	75			US	A _.		
	r dea	Funeral	11. Marital Status	12. Was Deceden Amed Forces	?	13.	Was Decedent of H	lispanic Origi an, Mexican,	in? (Specify Puerto Ric	y Yes or No- an, etc.)	14. R	ace - Ame	erican Indian, te, etc.	
21215-0036	. I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "natural" or items 23a or 28a-f show piner fraumatic svent, the Medical Examinar must be mailined at	þ	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🛣 Divorce	WVon Chin	™ 1944–46	5	1□Yes 2█ No	Specity:			Spec	ify: V	VHITE	
) O	72 hou	Completed	15. Deceder	nt's Education est grade completed)		a. Dece	dent's Usual Occup	ation	of working		16b. Kind of	Business	/Industry	
21	ithin 7	nple	Elementary/Secondary (0-12)	College (1-40)	5+)		kind of work done DO NOT use retired	d)	or working		DIIDI	T.O. 11	m = 1 T m = 2	
2	iled w Hygier ther th		7 17. Father's Name (First, Middle,	(act)		FU.	REMAN	19 Mother	's Name /F	iret Middle	Maiden Suma		TILITY	
Maryland	ld be i ental i ked oi ic svs	To Be	ARTHUR											
ary	shou and M a mar umat	-	19a. Informant's Name/Relations	. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number									Zip Code)	
Σ	and 2 salth a n 27 li		HERBERT C. WIL	HELM/COUSIN			5 BOX 96E	, SRLI	BYVILI	LE, DE	. 1997	5		
ore.	Pages 1 nent of He ant: If iter ury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐Removal from State	namat		sition (Name of matory or other plac	· 1	Date		20c. Location			
Baltimore,			`4 □Donation 5 □Other (S		DEL.		ERANS CEM		7/7/04	4	MILLS	BORO	, DELAW	ARE
Ba	permit. Departn Imports any inju		21. Signature of Funeral Service	Jun 1	7	- 11	ASTINGS F		L HOMI	E, SEL	BYVILL	E, DI	E. 1997	5
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that cause t only one cause on each	ed the death. Do	not ent	er the mode of dyin	g, such as c	ardiac or re	spiratory ari	rest,		Approximat Interval Bet Onset and	ween
À.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	CONARY	h	HETERY	_ D1	SCA	SE			Oligot and t	Doutii
	Examiner		disease or condition resulting in death) a. CROVARY ARTERY DIS CASE Due to (or as a consequence of):											
	D =	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequenc	a of).								
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for a		a a4\.						_		
8760,	be executed sician and burial-transit	al E		Due to (or a	s a consequence	e or):								
687	tificate ig physi as the	edical		d										
Вох	ath certific attending p for use as	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal deat	b 3	Ectopic pregnancy				23d. D	ate of del	livery	
O. B	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death		Other (specify)				N	lonth	Day *	Year
4	res that th igned by be detac		Part II. Other significant conditi	ions contributing to death	but not resulting	in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use co	ntribute to	the cause of d	feath?
of Vital Records,	w requires been sign should be	ed by	CHRONIC	RENAL	FAILY	RE				1 □ Y	es 2 🗆 No	3 □ Pr	obably 4 De	nknown
eco	e law re has bee ge 2 sho	Completed							_	24a. Was a			utopsy findings completion of c	
E B		Com								perfor	med? 2 No	death?		2000 0.
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			Oth		of Death (C	heck only or	ne)			
of	Phys this ral di	. To	1 Yes 2 No 27. Mann Death	1 ☐ Inpat		outpatier Time o		41 Nurs			ence 6 00 ow injury occu		cify)	_
on	Attending F or death. ector: After by the funer	atlor	1 Natural 5 Pendi 2 Accident invest		ay Year)	Injury	Wor	k? Yes 2∐No			,,			
Division	f or Attendia after death. Director: A	Certification:	3 Suicide 6 Could 4 Homicide	nined 288. Place of II	njury - At home, etc. (Specify)	farm, str	eet, factory, office		28f.	Location (S City or Tow		ber or Ru	ural Route Num	ber,
_	Hospital A hours Funeral ety filled	edical Co	(Chleck ohly 2 ☐ Medical	ng Physician: To the bes Examiner: On the basis	of examination a	ge, deat	n occurred at the tin	ne, date and pinion, death	place, and occurred a	due to the cat the time, o	ause(s) and n	nanner as	stated.)
	To the H within 24 To the Fi complete	Med	29b. Signature and title of certific	and manner s	stated.		29c. Licens				29d. Date sign			
	Ω							5006			JUU	4 3	3 2006	P
	6 my		30. Name and 10 ress of person	who completed cause of	death (Item 23a) (Type,	Print) MOTIAN							/
	١٠		614-			RE	DRIVE	1 June	1156	BURY	MO	2	1804	
	Sta Registi			31. Date filed (Month, Day, Year) JUL 0 8 2004 32. Registrar's Signature Server Server									/	
		V.	JUL U	0 2004		/	· /							

			For State of Maryland / Dep 1 - State Ragistrer Ce	eartment of Health and N ertificate of Death		iene ag. N2 () () (,	23789
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Dear Month	Day Year	3. Time of Death
	/Medic		Byard Whaley Collins, Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July	7, 2004 4c. County of Dea	10:30 A M
			Salisbury Nursing and Rehab Center	Salisbury		Wicomico	
	Funeral Director		5. Social Security Number 215–14–3578 6. Sex 1 ▼ X 2 □ F 7. Age (In yrs. last birthday Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, March 9	Year) 9. Bir Co 1923 Maj	thplace (State or Foreign ountry) Cyland
/land	Mor TR		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
e Man	Sa-f st	Director	Maryland Wicomico Salis	oury			1 ☐ Yes 2 XNo
death with the Maryland	e or 28		10e. Street and Number	10f, Zip Code	1	0g. Citizen of What Co	ountry?
death	ms 23	Funeral	317 Craft Street 11. Marital Status 12. Was Decedent Ever in U.S. 13	21804 . Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ame	
5-0036 72 hours after	at of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23e or 28a-f show or other treumatic event. It a Medical Evarther must be inclined at	by Fui	Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: ТАТАТТТ	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Hican, etc.)	Black, Whit	
5-0030 72 hours af	aturel cul Ev		15. Decedent's Education 16a. Dec	edent's Usual Occupation	. 1	16b. Kind of Business	White Industry
	nen "n Medi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing		
M pelil	and Mental Hygiene. Is marked other then eumatic event, If a Me		8 —— Sa. 17. Father's Name (First, Middle, Last)	les & Service	e (First, Middle, I		ion Equipmen
id be	fental rked o tic eve	To Be	Roland Marvel Collins	Lulu	Ellen		ey
	and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Run	al Route Number	, City or Town, State, .	Zip Code)
- 0	Health em 27 ther tr		20a Method of Disposition 20b. Place of Disp	Carey Street, Fruit		aryland 2	1826
Pages	ent of nt: If it ry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cri	ematory or other place)			
Dailtimor	Department of Importent: If it any injury or one		21. Signature of Funeral Service License	Memorial Park July 1 22. Name and Address of Facility Holloway Funeral Ho		-	
n &	<u> </u>		Month II wound (1)	OUL Snow Hill Road	, Salisb	ury, Maryl	and 21804
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause or pach list. Immediate Cause (Final		or respiratory arre	est,	Approximate Interval Between Onset and Death
	iysician Medical		disease or condition resulting in death) Due to (or as a consequence of):	ancer ?			Ma the
E	caminer		Sequentially list conditions. b. Connerg of	Fers Dice	-		40017
pet	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
О, өхөси	an and rial-tra	Ехаг	that initiated events resulting in death) Last Due to (or as a consequence of):				flor
os/ou, ificate be executed	physician and s the burial-transit	edical	d				
	ding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of del	E
the death cert	been signed by the attending p should be detached for use as	Physiclan/M	in the past 12 months? 1 Vec. 2 No. 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	Day Year
r the C	d by the	Phys	9 Unknown		00. 17:44		
The law requires that	signe d be d	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		eacco use contribute to es 2 □ No 3 □ Pr	othe cause of death? obably 4 □Unknown
COLOS aw requires	s been s shou	Completed			24a. Was a		itopsy findings available
	is certificate has director, page 2	Com			autops perform 1 Yes 2	y prior to death? No 1 ☐ Yes	completion of cause of
Of VItal Physicien:	certific rector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death	(Check only on	9)	
Phys	± 100 €	7: To	27. Manney of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		nce 6 Other (Spe w injury occurred	cify)
IVISION r Attending	ath. vr. After ne funera	atlo	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
JIVIS or Atte	within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,
Lepite	nerei I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the ca	use(s) and manner as	stated.
the Ho	in 24 the Fu	Medical	(Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, da	ite and place, and due	to the cause(s)
Tot	To 1	Σ	29b. Signature and title of certifier	29c. License number	25	7 Date signed (Month	h, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		11/04	
VB	Q	Į,	William Robins, M.D.	1346 S. Division S	t.Suite,	Salisbury,	Md.21804
E	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 8 2004 32. Registrar's Signature	South		•	

				pe or Print in B					_	e.
			1 - For State Registrar	State of Maryland		tificate of			giene 10g. N J. 0 0 4	23790
	Physici	an	Decedent's Name (First, Middle, Last) GLADYS MARIE	COLLINS				2. Date of Dea Month	Day / Ye	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, o	r Location of Dea	th	4c. County of I	
			PENINSULA REGIONM 5. Social Security Number 6. Sex	Medical Class		SAU.		Doto of Birth		100/00
ı	Funeral Director			7. Age (iii yis. ia	Yrs.	Months Days	Hours Min		, Year) , 1928 D	Birthplace (State or Foreign Country) ELAWARE
	nand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	e Man	Director	DELAWARE SUSSEX		MILLS	BORO				1 □ Yes 2 No
	with th	i Dire	10e. Street and Number 21730 DOTS ROAD			10f. Zip Code 1996	56		10g. Citizen of Wha	t Country?
	ems 23	Funerai		. Was Decedent Ever in U.S Armed Forces?	S. 13. \			Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
36	filed within 72 hours after death with the Maryland Hygiene other than "naturel", or Items 23s or 28s-f show ont, the Medical Examiner must be netified a	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:		I□Yes 2∏ No	Specify:	,	Specify:	WHITE
215-0036	72 hou	eted	15. Decedent's Educa (Specify only highest grade of		(Give	lent's Usual Occup	during most of wo	orking	16b. Kind of Busin	ess/Industry
LZ.LZ	filed within Hygiene. Ither than '	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		OO NOT use retired EMAKER	1)		OWN HO	ME
	d tal	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Sumame)	
Maryland	2 should and Men Is marke eumatic	10	CHARLES H. ROGE 19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street	MAGGIE and Number or R		McCABE r, City or Town, Sta	te. Zip Code)
	nd 2 lith a 27 ls		BECKY L. MURRAY /		3791) MERRILI		MILLSBORC	, DELAWAI	
ore	0 0		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Rer	noval from State	metery, cren	sition (Name of natory or other place			20c. Location - City	
Baltimore,	permit. Page Department Importent: If any injury o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	DE I H	IEL CE	METERY Name and Addre ATSON_FUN			WILLARDS	, MARYLAND
n	89128		Reckard T. Co	atson		ll WASHIN	IGTON STI	REET, MIL	LSBORO, I	
	Physician		Part1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final)	cause on each line.	Do not enti	er the mode of dyin	ig, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	ence of):					
	Lammer	e	Sequentially list conditions, b. if any, leading to immediate	Due to (or as a conseque	ence of):					
	be executed ician and burial-transit	aminer	cause. Enter Underlying Cause (Disease of high that initiated events resulting in death) Last							
68/60,	e be exe sician a burial-	cai E	d	Due to (or as a consequent	ence or):					
	ertificate l ing physi e as the b	Medic	IF FEMALE:							
X Q Q	The law requires that the death certificate tie has been signed by the ettending phys age 2 should be detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de.	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
r Ö	at the de	Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
ds,	uires thai n signed b ld be det	þ	Part II. Dther significant conditions contr	buting to death but not resul	lting in the ur	iderlying cause giv	en in Part I.		bacco use contribut es 2 □ No 3 □	te to the cause of death? Probably 4 Unknown
ecords,	law require as been sig 2 should b	Completed						24a. Was a	n 24b. Were	e autopsy findings available to completion of cause of
r								perform		h?
ı Vıtal	di S	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 12 Inpatient 2 🗆 E	R/Outpatien	t 3□ DOA Cth	00	ath <i>(Check only on</i> Home 5 ☐ Reside	ence 6 Other (S	Specify)
0 UC	fune		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Worl	yat k? Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division	Atten er deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre		103 2 110	28f. Location (St City or Town	reet and Number o	r Rural Route Number,
5	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in			ian: To the best of my know			and data and also			
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	(Check only 2 Medicel Examine one)	r: On the basis of examination and manner stated.	on and/or inv	estigation, in my o	pinion, death occ	e, and due to the coursed at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier		1	29c. Licens	e number	2	9d. Date signed (M	onth, Day, Year)
			30. Name and address of person who com	pleted cause of death (Item	23a) (Type, I	Print)	14 19	(18) CY, MD	1/8/0	7
			Simple Eng	100 E. Carl	011,	5+,5	alisbur	y, MO	21801	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	29	Spark				
	_	-								

State Registrar

			For State Registrar	State of Maryla	ind / De		lealth and N	lental Hy		23791
•	Physicia /Medio Examin	al	1. Decedent's Name (First, Middle, L. 2 WOOD 4a. Fecility Neme (If not institution, gi	5. Custer	tapo	4b. City, Town, o	or Location of Death	2. Date of Dea Month 07-11	-2004	3:15 p.m
45	Funeral Director		J-41	Sex 7. Age (In yrs	s. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 11-13-1		Birthplace (State or Foreign Country) NNSYLVANIA
	he Maryland 8e-f show	Director	10a. State 10b. County MD WORCE		City, Town	IN a track				10d. Inside City Limits Y□ Yes 2 □ No
	23a or 2	rai Dire	10e. Street and Number 49 FALCON BRIDGE				21811		10g. Citizen of What USA	Country?
036	ilied within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-1 show int, Ite Medical Evardinar must be notified at	l by Funerai	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates:	U.S.	13. Was Decedent of H If Yes, specify Cub.	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		merican Indian, hite, etc. WHITE
15-0	in 72 ho n "natur dedical	Completed	15. Decedent's E (Specify only highest gi	ade completed)	16a. C	lecedent's Usual Occup Give kind of work done ife. DO NOT use retire	pation during most of work d)	ing	16b. Kind of Busine	ss/Industry
r Edward Maryland 21215-0036	e filed within al Hygiene. other than		12 17. Father's Name (First, Middle, Las	College (1-4or 5+) 2	C	RYPTOLOGIST		e (First, Middle.	NATIONAL Maiden Sumame)	SECURITY
Edward yland 21	od parity of o	To Be	JOHN A. CUSTER	,			MABLE SC			
	od 2 :		19a. Informant's Name/Relationship MARILYN CUSTER -			Mailing Address (Street FALCON BRII			•	·
Custer altimore, M	00		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 [Removal from State	cemetery,	Disposition (Name of crematory or other place	ce)	Date	20c. Location - City	
C. Baltin	permit. Pages Department of Important: If I any injury or one		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	the state of the s	EMATO		ss of Facility BO	UNDS FUN	VERAL HOME	
•	Physician /Medical Examiner	liner	23a. Part Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nplications that caused the property of cause on each line. a	equence of	t enter the mode of dyir CANC	ng, such as cardiac			Approximate Interval Between Onset and Death
68760,	cate be executed physicien and the burial-transit	dical Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):				
P.O. Box 6	Physician: The law requires that the death certificate in this certificate has been signed by the attending physical director, page 2 should be detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preging the preging the first and the pregnant at time of the preging the pregnant at time of the pregnant at time at	etal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	1		23d. Date of o Month	delivery Day Year
ds, P	uires that I signed by id be deta	by	Part II. Other significant conditions	contributing to death but not re		he underlying cause giv	ren in Part I.	1		o to the cause of death? Probably 4 Honknown
Recor	he law requ e has been ige 2 shoul	Completed	Ulo seps,	S				24a. Was autop	sy prior t	autopsy findings available to completion of cause of
/ital	sician: The law certificate has t irector, page 2 s	Be Co	25. Was case referred to medical examiner?				26. Place of Deat	1 ☐ Yes h (Check only o		es 2 110
Division of Vital Records,	nding Physi th. :: After this c e funeral dire	ation: To	1 Yes 2 NAo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	□ ER/Outp 28b. Tin Inju	ne of 28c. Injur	4 _ Avursing no		lence 6 Other (S) ow injury occurred	oecify)
Divis	Hospitel or Attending Anours after death. Funerel Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not determined		home, farm	n, street, factory, office	V.	28f. Location (5 City or Tow	itreet and Number or n, State)	Rural Route Number,
	_ (4 _ m	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, nation and/	death occurred at the tir or investigation, in my o	me, date and place, pinion, death occur	and due to the o	cause(s) and manner date and place, and d	as stated. iue to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	e Suff	L,	29c. Licens	e number / 2006	795	29d. Date signed (Mo	nth, Day, Year)
VIFU	AG		30. Name and address of person who	completed cause of leaf (Ite	em 23a) (T	ype, Print) 09 CBAS-	ACH6	tersy	Favur	CK FRUANDO
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	5 Sour	h			Lini

Box 68760. P.0. Division of Vital Records,

1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Yeer **Physician** 1300 JEANNE L. CANDEL 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Memorial HOSPHOU at Easton EOSTO If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. SEPT 9 1960 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 PA **Funeral** 1 □ M 2 F Director 190-50-5932 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be natified at once. 1 Yes 2 No Directo TALBOT CORDOVA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 30808 RABBITT HILL ROAD 21625 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 3 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY AUTOMOTIVE REPAIR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JACK PHILLIPS ELMA GRUNEBURG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEITH C. CANDEL/HUSBAND 30808 RABBITT HILL ROAD, CORDOVA, MD 21625 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 3 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR. 7-15-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA NOHOK. MERCEROI 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 **N**o 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Tyes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Lettifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29d. Date signed (Month. Day, Year) 04 $W \iota$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID SMITH M.D. 29466 PINTAIL DRIVE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 12 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Vital
of
Division

		Please Type or Prin	t in Black In	delible Ink. Ensu	re All Copies A	re Legible.
		_ 701	-	artment of Health		0001
		1 - State Registrar	Ce	rtificate of Death		23793
Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
/Medic		MARGARET G. COLLINS 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location		14 2004 4:40 AM 4c. County of Death
Examir	ier	Genesis ElderCare - Th	ne Pines	Easto		Talbot
Funeral	Г		(In yrs. last birthday)	If Under 1 Year If Under Months Days Hours		
Director		213-00-3002	39 Yrs.	Months Days Hours	JAN 17 1	915 MARYLAND
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
Maryl -f sho	to	MD TALBOT	EASTON			1 ☐ Yes 21 No
h the	Director	10e. Street and Number	_	10f. Zip Code	10	g. Citizen of What Country?
death with the Maryland rms 23a or 28a-f show ruset be rediffed at	alD	9476 GULLEYS COVE LANE		21601		USA
er dea	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
UU36 hours atter death with the Marylan ural; or Itams 23a or 28a-1 show al Examerer until be rediffed at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 溢 N If Yes, Give Year or Dates:	0	1 ☐ Yes X No Specify.	:	Specify: WHITE
P	ted	15. Decedent's Education		dent's Usual Occupation	16	6b. Kind of Business/Industry
1215- within 72 ane. than nat	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	life.	kind of work done during mos DO NOT use retired)	st of working	
N pob		7 0		HOMEMAKER		OWN HOME
a la b	Be	17. Father's Name (First, Middle, Last) JOHN WESLEY DAWSON			er's Name <i>(First, Middle, Ma</i> NAOMI SEDGWIC	The state of the s
P P P P P P P P P P P P P P P P P P P	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Maili			City or Town, State, Zip Code)
M62 alth a 27 is r trav		JOAN N. WOLFF/DAUGHTER		6 GULLEYS COVI		N, MD 21601
Saltimore, I service,		20a. Method of Disposition	20b. Place of Dispo	esition (Name of matory or other place)	Date 20	0c. Location - City or Town, State
AITIMOF mit. Pages partment of cortant: If its injury or o		1 △Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		MEMORIAL PARI	x 7-17-2004	EASTON, MARYLAND
Dalti permit. Departm importa		21. Signature of Funeral Service Licensee		Name and Address of Facili		M FUNERAL HOME P.A.
T 707.9		JOHN R. MERCER		OO S. HARRISOI	N ST EASTON.	MARYLAND 21601
		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final	e.	er the mode of dying, such as	cardiac or respiratory arres	t. Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	YMAN	failure		days
Examiner		2.5	consequence of):	,		weeks
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):	1 0	į ·	DVCCIO
be executed sician and burial-transit	Examln	that inflated events c.	remer	or deme	nXIa	Veary
be exe		resulting in death) Last Due to (of as a	consequence of):		•	/
BOX 58 // Seath certificate be attending physic	Physician/Medical	d				
. BOX 08/ death certificate e attending phys of for use as the	n/Me	IF FEMALE: 23c. If yes, outcome of the control of t				23d. Dale of delivery
G for	icia	in the past 12 months?	_	Ectopic pregnancy Other (specify)		Month Day Year
that the d	hys	9 ☐ Unknown				
8 g g	by F	Part II. Other significant conditions contributing to death but	t not resulting in the u	nderlying cause given in Part I		cco use contribute to the cause of death?
COLDS, wrequires been sign should be	eted				1 Yes	2-☐No 3 ☐ Probably 4 ☐Unknown
has has	ompleted				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Pate 1	O	25 W				d? death? 1No 1 ☐ Yes 2 ☑ No
90 /0 =	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatier	Other	of Death (Check only one)	- 0 FO0+ (0
	\vdash	27. Manne Death 28a. Date of Injury	28b. Time of	28c. Injury at	ursing Home 5 🗌 Resident 28d. Describe how	
Attending rideath. ector: After by the fune	atlo	2 Accident investigation	Year) Injury	Work? M 1 ☐ Yes 2 ☐	No	
LIVISION I or Attending after death. Director: After	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Inju building, etc	ry - At home, farm, str. (Specify)	eet, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
Urs aff					1	
To the Hospital of within 24 hours and To the Funeral Completely filled it	edical	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manners and manners and manners.	examination and/or in	n occurred at the time, date an vestigation, in my opinion, dea	id place, and due to the cau- ith occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	(11)	29c. License number	_7 290	. Date signed (Month, Day, Year)
FSFO		+ Hotel 40	and	D257	50 7.	-14-04
		30. Name and address of person who completed cause of de	ath (Item 23a) (Type,	Print)		- MA -
		KOBERT SANCHEZ, MD	508 In	LEWILD HVE	NUL LAST	av, 111) 21601
Sta Registr		31. Date filed 1 1 1 2 2004 32. Registra	r's Signature	A .		
DHMH 17 Rev 1/2		1110	J. Spank		12.4	
	J. J.		ORIGIN	AL		

_			1- For Amend Item #1State of Maryland / Item	ppartment of Health and Med Certificate of Death	834H891290404 23794
Г	Physici	an.	1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Year 3. Time of Death
	/Medic		DONALD WAYNE DOYLE, JR.		July 19, 2004 0834 A ^M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	•		Peninsula Regional Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last bird		Wicomico
	Funeral Director		+57 M 20 E	Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 9. SALISBURY, MD.
	D .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	10d leade Chut :- h-
	farylan show	5			10d. Inside City Limits 11☑ Yes 2 □ No
	28a-	Director	MD WICOMICO FRUITL 10e. Street and Number	AND 10f. Zip Code	10g. Citizen of What Country?
	a with	ā	503 HAYWARD AVENUE	21826	
	ter deeth Items 2 Irec mu	Funerai	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specifi If Yes, specify Cuban, Mexican, Puerto Ric	USA / Yes or No- 14. Race - American Indian,
920	72 hours after deeth with the Maryland neturel', or items 23a or 28a-f show disul Eva-, if act must be multiled at	by	1 ☑ Never Married 2 ☐ Married 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 ☑ No Specify:	an, etc.) Black, White, etc. Specify: WHITE
21215-0036	be filed within 72 hours after deeth with the Maryla hat Hyglene. of other than "neturel", or Items 23a or 28a-f show event, the Medicul Evar. ir at rivest be notilised at	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
	filed wi Hygien other th	S		NEVER WORKED	NEVER WORKED
gue	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)		irst, Middle, Maiden Surname)
Maryland	s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic eve	ဥ	DONALD WAYNE DOYLE, SR. 19a. Informant's Name/Relationship (Type, Print) 19b.	BRENDA MAE	
₹	id 2 sho th and I to ma treums		DONALD WAYNE DOYLE, SR FATHER 41	Mailing Address (Street and Number or Rural Re	
ē,	Health tem 27 other tr		20a. Method of Disposition 20b. Place of	Disposition (Name of Date	
9	8° = 5		I XBunai 2 Cremation 3 Hemoval from State	y, crematory or other place) HILL MEM. GDNS. 07-23-	2004 HERDON MADVIAND
Baltimore,	permit. Pag Department Importent: I any inlury c		21. Signature of Funeral Service Licensee	22. Name and Address of Facility BOUN	DS FUNERAL HOME, INC.
			23a. Parl. Enter the disease, or complications that caused the death. Do n		SALISBURY, MARYLAND 21804 Spiratory arrest. Approximate
le .	Physician /Medical Examiner	пег	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	f):	erapamil, and Hydrocodone)
68760,	ficate be executed physician and s the burial-transit	edicai Examin	Cause (Disease or injury that initiated events resulting in death) Last c	f):	
.O. Box	the death certi by the attending ached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
rds, P	quires that n signed b	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 💆 Unknown
of Vital Records,		e Completed	25. Was case referred to medical		24a. Was an autopsy performed? 1 Yes 2 \(\) No 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\) Yes 2 \(\) No
5	- 02	o Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ☐ FP/Out	26. Place of Death Contact of Death Con	
	g Phye er this eral di	H	27. Manner of Death 28a. Date of Injury 28b T	ime of 28c. Injury at 28d.	5 ☐ Residence 6 ☐ Other (Specify) Describe how injury occurred
0	full At h	atlo	1 Natural 5 Pending Power Day Year) 2 Accident investigation 7/19/2004 7:00	A M 1 Voc 2 PAIN	known
Division	of or Attendent effer death Director:	ertification:	3 ☐ Suicide 6 【X Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify) Residence	m street factory office 28f.	Location (Street and 503er Hayward Vir Ave., City or Town, State) Md
	To the Hospitel or I within 24 hours efter To the Funeral Directonpletely filled in b	edicai C	29a. Certifier (Check only one) 1□ Certifying Physicien: To the best of my knowledge, 2▼ Medical Examiner: On the basis of examination and manner stated.	death occurred at the time, date and place, and	due to the cause(s) and manner as stated
	To th within Fo th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)	. ,,,,		I Sample Sirithall Mr	OCME	July 21, 2004
			30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)	
			Pamela E-Southoul, MD	111 Penn Street.	Baltimore, Maryland 21201
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	& Sports	,,
	negisti	ai .	JUL 2 3 2004 Beneva	1- 1-1-1-2	

			1- For State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death	lental Hygie	•	23795
	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Doris Easton		2. Date of Death _Month JULY	8 ^{Day} 2004	3. Time of Death 2138 M
	/Medio Examir		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	bary	4c. County of Deat Anne Ar	h
	Funeral Director		5. Social Security Number 578-50-6423 6. Sex 1 M 2 MF 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y NOV 12	9. Birt 1936 D.	nplace (State or Foreign untry)
	e Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le Maryland Anne Arundel Arnole				10d. Inside City Limits 1 X Yes 2 No
	th with the	Funeral Director	1363 Shirleyville Rd.	10f. Zip Code 21012	10g	Citizen of What Co USA	untry?
980	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show glical Examinar must be notified at	by	1 Never Married 2 Married 1 Yes 2 No 1	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🌠 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B	
21215-0036	within ane. than "	Completed	(Specify only highest grade completed) (Give life.	dent's Usual Occupation I kind of work done during most of workil DO NOT use retired) ninistration	ng	Sb. Kind of Business/	
Maryland ?	be filed stal Hyg ad other event,	ae	17. Father's Name (First, Middle, Last) Clevous Duncan	18. Mother's Name Eva Will	(First, Middle, Ma		
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Daniel Easton(Husband) 1363	ng Address (Street and Number or Rura Shirleyville Ro			
Baltimore,	Page nent o nt: If iry or			osition (Name of matory or other place) AME Church 7-1		c.Location - City or alesvill	
Ball	permit. Dapartm importa any inju			Mameria Address of Eacilistons 21 West St. Ann			01
	Physician		23a. Part Nenter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	er the mode of dying, such as cardiac o	r respiratory arrest	i,	Approximate Interval Between Onset and Death
	/Medical Examiner	-	Due to print is a or nsequence (f):	monary eder,	na		
_	ate be executed hysicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):	cardiomyopa	thy		
68760	ficate be e g physicien as the buri	icai	Coronary.	artery disea	se		
P.O. Box	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of deliving Month	very Day Year
	law raquires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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of Vit	shys al di	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatien 27. Manner of Ceath 28a. Date of Injury 28b. Time of		ne 5 🗆 Residence		fy)
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	ro the Printin 24	Med	and manner stated.				
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	Director		578–50–0393 Usual Residence of Decedent 10a. State 10b. County	66	Yrs.					1-5-19	38	Was	hington, DC
Marylaı d 2 should b	rtment of Health and rtant: If Item 27 ie m njury or other traum	To Be Completed by Funeral Director	Maryland Queen And 10e. Street and Number 106 Holly Ct. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last) George R. 19a. Informant's Name/Relationship (Ty) Patricia J. Eberly 20a. Mathod of Disposition 1 Sturial 2 Cremation 3 R. 4 Donation 5 Other (Specify)	12. Was Decedent Ever is Amed Forces? 1	Steven 10. S. 13. 13. 13. 13. 13. 14. 14. 13. 14. 14. 14. 14. 14. 14. 14. 14. 14. 14	asvill 10f. Zip of 21 Was Deceded for Yes, specific Yes, yes, yes, yes, yes, yes, yes, yes, y	Code 666 ent of Hi fry Cubai XI No Cocupa k done d e retired, Plum (Street a Ct. e of ther place	specify: ation turing most of the results of the r	of workir 's Name Lel 'or Rural Vens D -12-	reify Yes or No-Rican, etc.) rig (First, Middle,ia Stau / Route Numbe SVille, ate.	Plumb Maiden Suma ably r, City or Town MD 216 20c. Location Davids	ace - Americack, White ack, White with: With Business/ling ame) 7. State, Zi. 666 - City or T. CONVIL	1 □ Yes 2 No untry? ican Indian, ,, etc. nite ndustry ip Code) Town, State Lle, MD
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Di To the Hospitet or	the Funer	edicai	one)	ician: To the best of my ker: On the basis of exam and manner stated.	knowledge, death ination and/or inv	estigation, ii	n my opi	inion, death	place, ar occurre	nd due to the ca d at the time, d	ause(s) and m ate and place,	anner as s and due to	stated. the cause(s)
To	To	Σ	29b. Signature and title of certifier	Acluh	mo	D	DD.	number 5323(6	2	July	9 th	Day, Year)
	Sta Registra		30. Name and address of person who con R. Bruce Helmly, M. 31. Date filed (Month, Day, Year) 12 20	I.D. 522 Id.	Yewild A		East	on, M	D 21	601			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** М Robert William Gibbs Ju1y 2004 7:05P/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2600 Compass Drive Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Director Nov. 1929 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglens.

That I ferm 27 is marked other than "raturel", or items 23a or 28e-1 ehow any or other treumatic event, the Medical Examiner man be multified at Maryland Anne Arundel Annapolis 1 XYes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA 2600 Compass Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12. Wes 2 \(\sum \text{No } 1950- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: by If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 1952 White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Office Furniture 17. Father's Name (First, Middle, Last)
John Gibbs 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Ciuffreda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorain S. Gibbs/Wife 2600 Compass Drive Annapolis, MD. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H importent: if its any injury or ot 1 DBurial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem, 7/14/04 importent: i any injury o Crownsville, MD. * 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Sen 22. Name and Address of Facility Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD. olun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ymshoma **Physician** yMTeer resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Year Dav 5 Other (specify) P.O. I ed by the a ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed) page 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 Tes After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature an of o rtifier 29c. License number 29d. Date signed (Month, Day, Year) 00051301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) are found some 300 Bestr

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24a. Was an autopsy performed autopsy findings availate provided autopsy performed autopsy findings availate provided autopsy performed au	rā	en sig	ed						1 🗆 Yı	es 2 No 3	Probably 4 🖾 Onknown
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed		ital c	S		1						
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30 Name and address of person who completed cause of death (from 32a) (Time Brist)				20 Name and address of cores	completed cause of death (the	am 22a) /F	Print)	1 10 2		1110	7
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babulal way, 106 Milhord ST# 504B, Salisbury, MD 21804	DE	2			106 Mil.	ford S	T# 50	4B, Sa	libury,	MD 2	21804
State 31. Date liled (Month, Day, Year) 32. Registrar's Signature 4 Apracle	6	Sta	ate	31. Date liled (Month, Day, Year)	32. Registrar's Sign	nature &	1	/ /	,		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Year DREENE **Physician** 5:00 PM Juli 2004 DWART /Medical 4b. City, Town, or Location of Quath 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner CAROLINE DENTON RUXTON HEALTH CARE CENTER If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NEW YORK 5. Social Security Number 7. Age (In yrs. lest birthday) Funeral Deys Months Hours 15√1 M 2□ F Yrs 102-16-3371 Director Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No Funeral Director KENT MAGNOLIA 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 234 HUNTER'S RIDGE WAY 19962 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: Race - Americen Indien, Black, White, etc. 11 Maritel Status 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRIC CO. 6 INDUSTRIAL ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be LAUKAITIS TILLIE CHARLES GREENE 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 234 HUNTER'S RIDGE WAY, MAGNOLIA. DE 19962 LUCILLE M. GREEN -WIFE Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: If it any injury or c MILLSBORO, DE DEL. VETERANS MEM. CEM. 7-12-04 22. Name and Address of Fecility 21. Signature of Funeral Service License BERRY-SHORT FUNERAL HOME m Show Herrel 119 NW FRONT ST., MILFORD, DE 19963 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner DIOM Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last THERO SLLEROTI MOIOUASCUL Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 ☐ Yee 2 ☐ No -ROL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 1 ☐ Yes 200No 1LL Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, eral Director: After this certifice filled in by the funeral director, Hospital • Funeral

To the within 2 5+IVA DG State

Reinbolo au 31. Dete filed (Month, Day, Year)

2 ☐ Medicai Exa

JUL 1 3 2004

4 ☐ Homicide

(Check only

29h. Signature and 1

29a. Certifier

one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 MD 32. Registrar's Signeture

TTENDING

Bloomsedale me Federalsburg

1 🖰 Certifying Physician: To the best of my knowledge, death occurrad at the time, date and place, and due to the cause(s) and manner as stated

iner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manuer stated.

29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar

		•	For State Registrar	S	state of M	arylan				ealth a			Reg. No	2001	238	01
	Physici		1. Decedent's Name (First, Midd Irene Harris	le, Last)								2. Date of De July	ath 8°	y 20 0 %	3. Time o	f Death M
7	/Medio Examin		4a. Fecility Name (If not institution Anne Arundel				r	Ann	apo:						rundel.	
	Funeral Director		5. Social Security Number 214-28-9458	6. Sex 1 ☐ M	7. A	ge (In yrs. 7	last birthday) 3 Yrs.	If Under Months	1 Year Days	II Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb 2	th y, Year	9. 8 931 Ma	inthplace (State Country) Tyland	or Foreign
	Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne		nde1		y, Town or Lo napol								10d. Inside C	City Limits
	h with the	Funeral Director	10e. Street and Number 701. Glenwood	Apt	512			10f. Zip 2	140	1.				itizen of What i	Country?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Middical Entriting from the Indiffication. Once.	by	11. Marital Status 1 Never Married XXMa 3 Widowed 4 Divorce	ried	Was Deceden Armed Forces 1 Yes 2 II II Yes, Give Year or Dates	? No	1	Was Dece II Yes, spe 1 \(\text{Yes} \)		ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.))-	14. Race - Ar Black, WI Specify:		
21215-0036	l within 72 ho lene. r than "natur rhe Medical	Completed	15. Decede (Specify only highe Elementary/Secondary (0-12) 6 th			5+)	16a. Dece (Give life. Home		rk done d se retired	ation during mos f)	st of worki	ng		Cind of Busines	ss/Industry	
	ld be filed ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle Louis Blunt				·			18. Mothe		(First, Middle ray	, Maide	n Sumame)		
Maryland	nd 2 shou Ith and M 27 is mar		19a. Informant's Name/Relation Patricia Matt			d Dau	19b. Maili 1ghter	ng Address	(Street	and Numbe	er or Rura mbia	A Beac	er, City h R	or Town, State d Shac	, _{Zip Code)} 20 dy Sid∈	764 e, Md
Baltimore,	Pages 1 arment of Heament: if item		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (noval from State	, La	Garde	osition (Na mater) Sin ens	me of Richardia Richarda	a 1 7	-13-	0ate - 0 4		idsonv	or Town, State	Md.
Balt	permit. Departr imports any inji		21. Signature of Funeral Service	Licensee	rese p	1004	183							y, P.A Md. 23		
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart lailure. Lis Immediate Cause (Final disease or condition resulting in death)	ar complica t only one	Deu Due to (or a	ed the deat line. Library s a conseq Library	th. Do not en	bilu	de of dyin	g, such as	cardiac	or respiratory a	irrest,		Approxima Interval Be Onset and	tween
3760,	ate be executed hysician and the burial-transit	ilcal Examiner	Sementially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	c. d	Due to (or a	s a consequence	quence of):	lto	Åα	S)						
P.O. Box 68	that the death certificated by the attending phydelached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c	. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Il death 3	⊒Ectopic p ⊒ Other (s)						23d. Date of o	delivery Day	Year
	ව වී		Part II. Other significant condit	ions contri	buting to death	but not res	sylting in the u	underlying (cause giv	en in Part I	l,		tobacco Yes 2		to the cause of Probably 4	death? Unknown
Division of Vital Records,	The law ate has b page 2 sl	Completed	,									24a. Was auto perfo 1 - Yes		prior t death		s available cause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?		spital:		1500		Oth	er		(Check only		a (70)		
on of	After fune	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc	ing	28a. Date of In (Month, D		28b. Time of Injury		28c. Injur Wor	4 L IN		28d. Describe		6 ☐ Other (Si uny occurred	pecity)	
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			30. Name and address of person	n who com	pleted cause of	death (Ite	m 23a) (Type	, Print)	NO	10	<u> </u>	2. 0		1-0	7	
	St	ate	31. Date filed (Month, Day, Yea	-10P1	2A MA 32. Fegis	D. C	DOK ature	age	TYA	v4. S	ste. Z	31 Anr	KUP	olisin	1D.214	01
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			For State Registrar			Maryland / De	epartment of liberation	Health ar	nd Mental Hyg	_	11.	2200	0.0
				ame (First, Middle	, Last)				2. Date of Dea	ath	I I.i.	3. Time of I	Death
	Physicia /Medic		RUBY	AGNES	HARRIS - (CLINE :			JULY	15 a	2004	5:38	PM
	Examin		4a. Facility Name	(If not institution	, give street and numbe	r)	4b. City, Town,	or Location of [Death	4c. County			
					ty Hospital		Hagerst		Hro o	Washi		Count	
	Funeral Director		5. Social Security 212-24-		6. Sex 7. A 1 ☐ M 2 ☑ F	Nge (In yrs. last birth 75 Yı	Months Days		Min. 8. Date of Birt (Month, Date of 18	h y, Year) 2 1028	9. Birthr	olace (State or otry) y Land	Foreign
			Usual Residence			,			ωι. π	1920	PEL	ytand	
	arylan show	<u>_</u>	10a. State	10b. County	1	10c. City, Town					1	Od. Inside City	•
	8a-f	Director		d Washir	igton	Smithsh						1 🗆 Yes	2 X 1140
	with is or i	Dir	10e. Street and i				10f. Zip Code			10g. Citizen of		itry'?	
	death	Funerai	11. Marital Statu	<u>Lilac La</u> s	12. Was Deceder	nt Ever in U.S.	21 783 13. Was Decedent of I	Hispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	U.S.A 14. Rad	e - Americ		
وي	after or Ite	Fur	1 Never M	arried 25 Marri	Armed Forces 1 Yes 2 F If Yes, Give		If Yes, specify Cub		Puerto Rican, etc.)		ck, White,	etc.	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene inaturel; or Itema 23s or 28s-f show ent, tre Pesilca Examiner must be notified.	d by	3 Widowed	4 Divorced	Year or Dates					Specif	wnı		
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<u>p</u>	be filed Ital Hyg Id othe event,	Be C	17. Father's Nam	ne (First, Middle,	Last)			18. Mother's	Name (First, Middle,	Maiden Suman	ne)		
<u>8</u>	should bind Menta	To E	Cliffor	d B. Gar	dner			Letha	a Smith				
<u>a</u>	12 sho			Name/Relations					or Rural Route Numbe			Code)	
	1 and Health em 27		Charles 20a. Method of D		ne / Husbar	nd 222 20b. Place of D	112 Lilac I isposition (Name of crematory or other pla	ane Si	mithsburg,	Maryla:		1783	
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П			23a. Part1. Ente shock, or h	er the disease, or leart failure. List	complications that cause only one cause on each	ed the death. Do no line.	enter the mode of dyi	ng, such as ca	rdiac or respiratory ar	rest,		Approximate Interval Betw	veen
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	/Medical Examiner		resulting in deat	,		s a consequence of		0.1.0	C 0		(_ /	
		er	Sequentially list if any, leading to	conditions, immediate	D	s a consequence of	RTKRY	DIJEA	16			yen	ms.
	outed id ansit	Examiner	Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated eve	nderlying or injury ents	.	,	•						
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× S	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE:		23c. If yes, outcom	e of pregnancy				22d Day	to of dollars		
Вох	death e atter d for u	iciar	23b. Was deced in the past 1 \(\superstack Yes\)	12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal death at time of death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у			te of delive Inth	-	ear
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ō	Attending Physician: r death. ector: After this certific by the funeral director.	Ju: T	27. Manner of De	eath 5 🔲 Pendin	28a. Date of In	jury 28b. Tin	e of 28c. Injur	ry at	28d. Describe h			/	
Division of	tendir leath. tor: Al the fu	catic	2 Accident		ation			Yes 2 □ No					
\leq	I or Attender deatl Director:	Certification;	4 - Homicid	data ma	ned 286. Place of t	njury - At home, farm etc. <i>(Specify)</i>	, street, factory, office		28f. Location (S City or Town	treet and Numb n, State)	er or Rura	Route Numbe	er,
	spital ours a neral filled		29a. Certifier	1 Certifyin	g Physician: To the bes	st of my knowledge.	eath occurred at the fil	me, date and c	place, and due to the c	ause(s) and ma	nner as st	n hate	
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edicai	(Check only one)	2 Medical I	examiner: On the basis and manner	of examination and/	r investigation, in my	pinion, death	occurred at the time, d	late and place,	and due to	the cause(s)	
	To the within To the Comp	M	29b. Signature a	nd title of certifie	1 2		29c. Licens		2	9d. Date signed	d (Month, L	Day, Year)	
	,2			W	KW		04:	3590		7-10	0-04	!	
4	4-10		/ 1 [/	ddress of person	who completed cause of			Tara	AC, MD	2170	2		
7	Sta	te.	31. Date/iled (M	onth, Hall Year)	0 2004 32. Regis	trar's Signature,	BLVD SMI	14000	-1/10	2178	۷		
	Registr	11114		JUL I	2004	trar's Signature	Spelle						

			For	ease				id / Depa	delible Inlartment of	Health a	and Me		_	jible.		
	Physici	ian	1 State Registrar 1. Decedent's Name (First, A			. i a		Ce	rtificate of	Death	-	2. Date of De.	Day /	Year		of Death
	/Medic Examir	cal	Sarah Jose 4a. Facility Name (If not instit						4b. City, Town,	or Location of	of Death	07/	12/0	ty of Death		OO PM
	Exami	iei	THE MEM	ORII	AL HO	05/	HAL		EAS	TON		TAlbot				
ì	Funeral Director		5. Social Security Number 218-01-9970) '	Sex 1□M 2√2 F	7. Ag		last birthday) Yrs.	If Under 1 Yea Months Days		Min.	3. Date of Birt 1 2 - 29	h y, Year) -1922	9. Birth Ne	place (State intry) avitt	or Foreign
	yland		Usual Residence of Deceder 10a. State 10b. Co	inty			10c. Cit	y, Town or Lo	ocation						10d. Inside	City Limits
	he Mar 28a-f sh	Director	MD Ta.	bot			St.	. Mich								s 2 No
	th with 23a or	ai Dir	101 Seymou	Av	enue				10f. Zip Code 216	63			10g. Citizen o	What Cou	ntry?	
326	in 72 hours after death with the Maryland "natural", or items 23s or 28s-1 show icalical Examinet mast be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo		12. Was De Armed F 1 Yes If Yes, G Year or	orces?			Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No		gin? (Speci i, Puerto Ri	fy Yes or No- can, etc.)		ace - Ameri ack, White, ify: Wh:	etc.	
2-003b	72 hou	eted	- 21	dent's E	ducation ade completed	1)		16a. Dece	dent's Usual Occu	ipation a during most	t of working		16b. Kind of	Business/Ir	ndustry	
7 7	ed within rgiene.	Completed	Elementary/Secondary (0- 10 years		College		5+)		kind of work done DO NOT use retire emaker	ed)			Home	9		
and	l be file	Be	17. Father's Name (First, Mic										Maiden Suma	me)		
ar y	2 should be and Mental Is marked of aumatic eve	5	George C. 19a. Informant's Name/Relat					19b. Mailir	ng Address (Stree			e Cam		n, State, Ziu	Code)	
Ž,			Lana Batter	(da	ughte	r)		3711	Rose		r.,_	Brigh	ton, N	1I. 4	18114	
ишоге	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other ti		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremat 1 □ Donation 5 □ Other	on 3 [r <i>(Specil</i>	Removal from	n State	20b. P	lace of Dieno	sition (Name of matory or other pla Vet Cei		Dat		00-1	A		
Dail	permit. Departimontal		21. Signature of Funeral Sen	1 1	1			E	Name and Addr	all H	יחות	y Fun	eral H	łome,	PC	
	Physician /Medical Examiner		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	o, or com List only	plications that one cause on Due to	caused each li	the death ne.	h. Do not ent	er the mode of dy	x 518 ing, such as o	St cardiac or r	Mich espiratory ar	aels,	MD . 2	21663 Approxima Interval Be Onset and 2 mg.	Dodin
i.	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į	b. Due to	(or as	a consequ	uence of):								
,00/00	cate be executed bhysicien and the burial-transit	573	that initiated events resulting in death) Last	l	c Due to	(or as	a consequ	uence of):					7			
O. BOX 0	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown			birth Inant at	of pregna 2 Fetal time of de	Ideath 3□	Ectopic pregnanc Other (specify)	ру 				ate of delive	-	Year
cords, r	uires that signed b	by	Part II. Dther significant con	ditions o	contributing to	death b	ut not resu	ulting in the ur	nderlying cause gi	ven in Part I.		23e. Did to	bacco use cor	_	ne cause of	
ממפנים	he law req e has beer age 2 shou	Completed										24a. Was a autop: perfor	med?	prior to con death?	psy findings	available cause of
g	ilan: T	BeC	25. Was case referred to merexaminer?	lical						26. Place	of Death (C	1 ☐ Yes Check only or	2 1 No	1 🗌 Yes	2 No	
> 5	hyaic this ce al dire	၉	1 ☐ Yes 2 ☑ No			Inpatie		ER/Outpatien	1 3 DOA				ence 6 🗆 Otl		r)	
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:		nding estigation		of Inju	ry y Year)	28b. Time of Injury	i i	ry at ork?]Yes 2 □ N		d. Describe h	ow injury occur	rred		
	tal or Atl	Certifi		ermined	28e. Plac	e of I n ji Iing, eta	ury - At ho c. <i>(Specif</i> y	ime, farm, stre	eet, factory, office		28f	. Location (S City or Town	treet and Num n, State)	ber or Rura	l Route Nun	iber,
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 ☐ Cert (Check only 2 ☐ Medi one)	fying Ph cal Exan	nysician: To th niner: On the l and man	pasis of	examinat	wledge, death tion and/or inv	occurred at the trestigation, in my	ime, date and opinion, deat	d place, and h occurred	due to the cat the time, d	ause(s) and m ate and place,	anner as st and due to	ated. the cause(s	s)
	To the total complete the complete the total complete the total complete the total comple	×	29b. Signature and title of cer	tifier	17/		1	4.0	29c. Licen	se number	/	2	9d. Date signs	ed (Month,	Day, Year)	
			30. Name and address of per	/ /					*	100			11101	vy		-
	Sta	to	Ludwie Egls 31. Date filed (Maria Day, Y)	ede:	r III,	MD .	. 50 ar's Signat	5 Dut	chmans	Lane,	East	on, M	ID. 21	601		
	Sta Registr		JUL 1	MI	2 1		A.	1	A A							

			For State Registrar	State of Ma	•	partment of Health and e <i>rtificate of Death</i>		giene Reg. No⊋ ∩ ∩	22001
∳			1. Decedent's Name (First, Middle, Las	st)			2. Date of De	path Day Yea	3. Time of Death
	Physicia /Medic		CATHERINE W. HOC	VER			JULY	14 200	6.4
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Location of Dea	ath	4c. County of De	eth
	· ·	-	WILLIAM HILL MAN 5. Social Security Number 6. S		- Alexandra de la bisabella	EASTON If Under 1 Year If Under 24 Hr	s c =	TALBO	
	Funeral Director			C. 450 -	6 (In yrs. last birthda 6 Yrs	Months Days Hours Mir		1907	irthplace (State or Foreign Country) IARYLAND
	land ow		10a. State 10b. County		10c. City, Town or	Location			10d. Inside City Limits
	Mary	tor	MD TALBO	т	F.	ASTON			1 X Yes 2 □ No
	th the	lrec	10e. Street and Number			10f. Zip Code		10g. Citizen of What (Country?
	23a c	al	501 DUTCHMANS LA	NE		21601		USA	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exc. alter traumatic event, the Modical Exc. alter traumatic event.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puentum 1	Specify Yes or No rto Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, lite, etc. WHITE
2-0	72 hc	eted	15. Decedent's Ed (Specify only highest gra		(G.	cedent's Usual Occupation ve kind of work done during most of w	orking	16b. Kind of Busines	s/Industry
121	vithin ne. han *	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life	. DO NOT use retired)		<u> </u>	
7	Hygie Hygie other t		12 17. Father's Name (First, Middle, Last)	00		HOMEMAKER	ama (First Middle	OWN HOM Maiden Sumame)	E
and	d be l	Be c	W. WIDERMAN				CE SMITH	, wardon oomano,	
Z	2 should be and Mental is marked of aumatic ev	2	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	uiling Address (Street and Number or F		er, City or Town, State,	Zip Code)
	1 and 2 Health a lem 27 is		ETHEL MANN/SISTER		98	D EAST SCHNELLVILI	LE RD., J	ASPER, IND	IANA 47546
J.	es 1 a of Hea fitem r othe	Ì	20a. Method of Disposition	5 44 60	20b. Place of Dis	position (Name of rematory or other place)	Date	20c. Location - City of	r Town, State
Ē	Pages nent of ant: If it		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify			N MEMORIAL PARK 7-	-17-2004	EASTON,	MARYLAND
Baltimore,	permil. Departr Importa any inj		21. Signature of Funeral Service Licen	S88		22. Name and Address of Facility FELLOWS, HELFENBE	TN & NEW	MAM FIINERA	I. HOME PA
	205 2 2		YOHN R.	MERC		200 S. HARRISON S	ST EASTON	, MD 21601	
	* *		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do not	enter the mode of dying, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cere	provascu	lex mynficience	4		yeurs
AST.	/Medical Examiner		1	Due to for as	consequence of):				June 4 mi
Agend		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of):				years
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C					
o,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a	consequence of):				
68760,	ate be hysici he bu	edlcal	•	d					
-			IF FEMALE:	222 16					
Вох	death cert e attendini id for use	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetel death	B Ectopic pregnancy C Other (specify)		23d. Date of do Month	olivery Day Year
o.	that the death certif ed by the attending detached for use a	Physiclan/M	1 ☐ Yes 2 € No 9 ☐ Unknown	9□ Unknown	tille of death	Cirel (specify)			
Δ.	The law requires that the tee has been signed by the bage 2 should be detache	by Pr	Part II. Other significant conditions o	ontributing to death bu	it not resulting in the	underlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds	w requires that s been signed b should be det	ed b					10	Yes 2 No 3 □ F	Probably 4 Unknown
Vital Records,	aw re	Completed					24a. Was		utopsy findings available
Ä		Com						rmed? death?	s 2 No
/ita	Attending Physician: The law r death. r death. ector: After this certificate has by the funeral director, page 2 s	Be (25. Was case referred to medical examiner?			26. Place of De	eath (Check only o	one)	
of \	Physic this c	2	1 Yes 2 No		nt 2 ER/Outpat			dence 6 Other (Sp	ecity)
ou c	ding F h. After funera	lon	27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day	Year) 28b. Time (Year) Injur	/ Work?	28d. Describe I	how injury occurred	
Division	death death ctor: , the	icat	2 Accident investigation 3 Suicide 6 Could not be		rv - At home farm	M 1 Yes 2 No	28f Location (Street and Number or F	Rural Route Number
Ω	or Attendent after death Director:	Certification:	4 Homicide determined	building, etc		street, ractory, critice	City or Tov	vn, State)	iola i iolo i volio i i
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowledge, de	ath occurred at the time, date and place	e, and due to the	cause(s) and manner a	is stated.
	he Ho in 24 he Fu pletel	edical	(Check only 2 Medical Exen	niner: On the basis of and manner sta	examination and/or ted.	investigation, in my opinion, death occ	curred at the time,	date and place, and du	e to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	M. A.		29c. License number		29d. Date signed (Mor	
,			7 //9	HILLON)	100	165727		7.16.0	1
			30. Name and address of person who	/			601		
		•		EY M.D. 50		LD AVE EASTONMD 21	601		
	Sta Registr		31. Date filed (Month, Day, Year)	to >	1 1	D.			
DH	MH 17 Rev 1/20	001		the state of	The state of the s				
					1 mm				

ORIGINAL

	State o	f Maryland / Depa	artment of Health and M	•	Legible.
	1 - State O	Cei	tificate of Death	Reg. No.	
Physician	1. Decedent's Name (First, Middle, Last) Ramon J. Julian, Sr.			2. Date of Death Month Day	3. Time of Death
/Medical	4a. Facility Name (If not institution, give street and nu	mher)	4b. City, Town, or Location of Death		2004 12:40 P. Mr.
Examiner	North Arundel Hospital		Glen Burnie		Anne Arundel
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign
Director	213-84-2730 ^{1⊠ M 2□ F}	88 Yrs.	Min.	April 1, 1	916 Philippines
and	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
Manyl 1 sho led s	Maryland Anne Arundel		Annapolis		MXYes 2 ☐ No
r 28a	10e. Street and Number		10f. Zip Code	10g. Citi	izen of What Country?
D36 us after death with the Maryland all, or Items 23a or 28a-f show examiner must be multified at by Funeral Director	1016 Kensington Way		21403		U.S.A.
r dea	11. Marital Status 12. Was Dec Armed Fo	edent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36 safte	1 ☐ Never Married 2XMMarried 1X Yes, Gir 3 ☐ Widowed 4 ☐ Divorced 1X Yes, Gir Year or D	2 □ No ve pates: WW II	1 ☐ Yes 2√2 No Specify:		Specify: Asian
5-0036 natural, or	15. Decedent's Education	16a, Decer	dent's Usual Occupation	16b. Ki	nd of Business/Industry
21215-00 ed within 72 hou yegiener arthan "neture it, the wedical Ed., the wedical Ed.	(Specify only highest grade completed) Elementary/Secondary (0-12) College ((Give life. I	kind of work done during most of workir DO NOT use retired)	ng	,
22 Maritimes 2	2	Tol	1 Collector		te of Maryland
७ ≘ x ≷ 5 m	17. Father's Name (First, Middle, Last) Luciano Julian		18. Mother's Name Mercedes	(First, Middle, Maiden	Sumame)
Tyle d Mer marke market	19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address (Street and Number or Rura		r Tourn State Zin Code)
Ma Inth an Ith an 27 is r	Maria Ramirez/daughter		Carbondale Way Ga		
Baltimore, Marylan Semit Pages 1 and 2 should be Department of Health and Mental Inger 11 item 27 is marked on any injury or other traumatic events.	20a. Method of Disposition	20b. Place of Dispo	sition (Name of pattern of pattern or other place)	ate 20c. Lo	cation - City or Town, State
Page Intry or	1XXBurial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State		5/2004 Dav	idsonville, MD
Balti Permit Deparm Importe any inpu	21. Signatur Suneral deryce Licensee	7 - 1 22	. Name and Address of Facility Joh	n M. Taylo	r Funeral Home
D	Joda E , a		7 Duke of Gloucest		lis, MD 21401
	23a. Part1. Enter the disease, or complications that of shock, or heart failure. List only one cause of	each line.	4	r respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	resulting in death)	NEU MON!	1		5 dens
Examiner	Due to		zelitus		5
P. P. P. P. P. P. P. P. P. P. P. P. P. P	Sequentially list conditions, b. Due to cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of):			3 years
8760, ate be executed hysician and the burial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events	dementia	-		3years.
60, be executed ician and burial-transit	resulting in death) Last Due to	(or as a consequence of):			
Box 68760, eath certificate be erath certificate be erathered by the second for use as the buriator use as the buriator where the control of the second co					
X 6 Se as	IF FEMALE: 23c If yes ou	tcome of pregnancy			
P.O. Box 687 nat the death certificate d by the attending phys letached for use as the Physician/Medic.	23b. Was decedent pregnant in the past 12 months?	oirth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	2	23d. Date of delivery Month Day Year
P.O. nat the d by the etached	1 Yes 2 No 9 Unknown 9 Unknown				
	Part II. Other significant conditions contributing to d	eath but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
ord:				1 ☐ Yes 2	XNo 3 Probably 4 □Unknown
Il Record The law requir atte has been s page 2 should	-			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
			_	performed2 1 ☐ Yes 2 No	death? 1 ☐ Yes 2 ☐ No
Vital Recipionism The law incien: The law contilicate has rector, page 2	examiner?	/	26. Place of Death		
Of Physical directly of To	1 Yes 2 No	npatient 2 ☐ ER/Outpatien of Injury 28b. Time of	4 Nursing Hon	ne 5 Residence 6	
On ading ading th.	1 Natural 5 ☐ Pending (Mon 2 ☐ Accident investigation	of Injury 28b. Time of Injury Injury	Work? M 1 ☐ Yes 2 ☐ No	,	
Division of Vital Records, for Attending Physician: The law requires the regard. The law requires the regard of the regard in the time and director, page 2 should be contification: To Be Completed by	3 Suicide 6 Could not be 28e. Place	o of Injury - At home, farm, string, etc. (Specify)	eet, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
Division c Teal or Attending P rs after death. Teal Director: After t led in by the funera Certification:	Build	ing, etc. (Opecny)		Only or rown, chare,	1
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director, Medical Certification: To Be C		asis of examination and/or in-	occurred at the time, date and place, a vestigation, in my opinion, death occurred	and due to the cause(s) and at the time, date and	and manner as stated. place, and due to the cause(s)
o the thin 2 or the mapped ample	one) and man 29b. Signature and title of certifier	ner stated.	29c. License number	29d. Date	e signed (Month, Day, Year)
F 3 F 8	A.A.	has	D 42977	Tal	8 20010
	30. Name and address of person who completed cause		Print)	J wy	10 dut.
	Cypicy Operanin 301	Hospity Drz	in Glan Burme	- ms. 2	11061
State	1000 4:0 2004	ngistraks Signature			
Registrar	JUL 17. 711114	Aller M. St.	and I		

			State of Maryla	nd / Department of Health and Mental H	lygiene
			Decedent's Name (First, Middle, Last)	2. Date of	Death 3. Time of Death
>	Physicia /Medic	al	MARY ADLENA BANKS JONES 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	y S 2004 153 i M
1	Examin	er	Dorchester General Hos		Dorchester
	Funeral		5. Social Security Number 6. Sex 7. Age (In yr		
	Director		214-07-9916 ^{1□M 2} ▼F 91	Yrs. Months Days Hours Min. (Month, Jan.1	Birth Day, Year) 0,1913 9. Birthplace (State or Foreign Country) Maryland
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. (City, Town or Location	10d. Inside City Limits
	sho	5			1₽Yes 2□No
	tha h	Director	Maryland Dorchester 10e. Street and Number	Cambridge 101. Zip Code	10g. Citizen of What Country?
	3a or		525 Glenburn Ave.	21613	USA
	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?		
ဖွ	after or Ite	F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 Yes 2 No Specify:	Specify:
21215-0036	d within 72 hours after death with the Maryland jiene. I then "netural", or Items 23a or 28a-f show the Mudical Examinar must be motified at	d by	3 Mag Wildowed 4 ☐ Divorced Year or Dates:		Black
5	"net	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
12	within iene. than "	E C	Elementary/Secondary (0-12) College (1-4or 5+)	Grader	Hanover Foods
p	Hyger H	ø	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	dle, Maiden Surname)
'lan		To B	Alfred Banks	Alice	tewart
Maryland	d 2 should th and Men 7 Is marks traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Nur	
	of Health item 27 other tr		Karnie Jones / Grandson	200 Everglade Dr., Salisbur	
ore	of H		1 Burial 2 □ Cremation 3 □ Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
Ë	nit. Pagartment ortant: injury		`4 ☐ Donation 5 ☐ Other (Specify)	alem Cemetery 07-14-2004	
Baltimore,	permit. Pag Department Important: any injury c		21 Signature of Funeral Service Licensee	22. Name and Address of Facility Bennie Smith Funeral Hom 516 S. Main Street, Hurl	e ock,Maryland 21643
			shock, or heart failure. List only one cause on each line.	eath. Do not enter the mode of dying, such as cardiac or respirator	y arrest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition Acute N	Goerndial Infraction	24 hrs
	/Medical Examiner		resulting in death) Due to (or as a cons	equence of): No Eclena.	241.
		፟	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		27 200
	ned insit	Ë	Cause (Disease or injury		
Ć.	exectin and ial-tra	Examiner	that initiated events resulting in death) Last	equence of):	
760,	ate be executed hysician and he burial-transit	Cal	d		
89	The law raquires that the death carificat ate has been signed by the attending phy page 2 should be detached for use as the	Med	IF FEMALE:		
Box	ath ca ttendi or use	an/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 2 F	etal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
	the a	Physician/Med	1 ☐ Yes 2 ☐No 9 ☐ Unknown 9 ☐ Unknown	f death 5 🗆 Other (specify)	
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Vital	ysicien: The l is certificate ha director, page	a)	25. Was case referred to medical	26. Place of Death /Check on	
of V		To B		□ ER/Outpatient 3□ DOA Other: 4□ Nursing Home 5□ R	esidence 6 Other (Specify)
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	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my large (Check only one) 2 Medical Examiner: On the basis of examiner stated.	knowledge, death occurred at the time, date and place, and due to t ination and/or investigation, in my opinion, death occurred at the tin	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			My Halden Ms	D26388	July 9, 2004
			30. Name and address of person who completed cause of death (I) Michinel J Facilies 3	tem 23a) (Type, Print) Or Culling Ave Hunlock	md 21643
ı	St Regist	ate rar	31. Date filed (Month, Day, Year)	tem 23a) (Type, Print) Or Coll rus rive I functional recomments and the time of the second recommendation and the second recommendation and the second recommendation and the second recommendation and the second recommendation reco	

Victor C. Knox 04-4498 AKG

170			For State	State of Maryland / Dep		Mental Hygien	ne
			Registrar		ertificate of Death	Reg. N	
	Physici	an	Decedent's Name (First, Middle, Last	1 1 1 1			ay Year 3. Time of Death
	/Medic	_	VICTOR CH	ARLION IIN	ت الان		2004 9:52 A ^M
<i>)</i>	Examir	ier	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	th 4	c. County of Death
A	*	'6' -	Cedar Hall Wharf & Sho		Pocomoke // If Under 1 Year If Under 24 Hrs		Vorcester
	Funeral		5. Social Security Number 6. Se	X 7. Age (III yrs. last birtida)	Months Days Hours Min	(Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	31		7-15-	67 VA
	/land		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Man	to	MD WICOM	1100 SAL	SRURY		1 x Yes 2 □ No
	r 28e	lrec	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
	h wit	al D	1115 - E. CH	URCH ST.	21804		USA
	dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
9	or It	Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: RIACL
003	urel',	d by	3 Widowed 4 Divorced	Year or Dates:	•••		DETICA
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or items 23e or 28e-1 show that the Medical Exertiner: ust be truffied at	Completed	15. Decedent's Edi (Specify only highest grad	le completed) (Giv	edent's Usual Occupation re kind of work done during most of wo _DO NOT use retired)	orking 16b.	Kind of Business/Industry
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d 21	filled Hygie ther ont,		17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maide	en Sumame)
an	d be antal	o Be	RUSSELL	KINY	Foode	-C SEHAA	(Feren KNOY
Maryland	2 should be filled within and Mental Hygiene. is marked other then aumatic event, It e Ms	2	19a, Informant's Name/Relationship (T	vpe, Print) 19b. Mai	ling Address (Street and Number or R	ural Route Number, City	or Town, State, Zip Code)
S	d 2 s Ith ar 27 is trau		Allen KILLY -	. WIFE 1115	FCHURCH ST	SALICANA	W MA 21804
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23s or 28e-f show may privary or other traumatic event, the Medical Extending to ust be intillised at ARCB.		20a Method of Disposition	20b. Place of Disp	position (Name of	Date 20c.	ation - City or Town, State
Baltimore,	Pages nent of H int: If ite	100	1 Burial 2 Cremation 3 1 Other (Specify,	removal from State	ematory or other place)	· Inu D	u= ms
₫	permit. Pag Department Important: I any inj. y o		21. Signature of the ral Service Licens	111111111111111111111111111111111111111	JM Ch. CEM 17/1 22. Name and Address of Facility	6/04 P BENNIE	promoke II)D.
Ba	permit. Departr Importa any int		Pan (~	tu		T. SAUSSU	
	- 12		23a. Part1. Enter the disease, or comp	lications that caused the death. Do not e			Approximate
1	Dhusisian		shock, or heal failure. List only of immediate Cause (Final	*			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. DROWNING Due to (or as a consequence of):			
ė	Examiner						
		je.	Sequentially list conditions, Tany, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	C.			
ó	sician and burial-transit	EX	resulting in death) Last	Due to (or as a consequence of):			
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9		Med	IF FEMALE:				
Вох	eath certific attending p I for use as	an/I	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day Year
	es that the death igned by the atte be detached for	Physiclan/Me	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death 5 9☐ Unknown	Other (specify)		Month Day real
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Н	The page	Completed				performed?	death? 10 1 Yes 2 No
Vital	ding Physicien: The lar n. After this certificate has funeral director, page 2	Be	25. Was case referred to medical examiner?) 		ath (Check only one)	
of	Physic this c	P	122165 2 100	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			6 Nother (Specify) at scene
n 0	After After funer	on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	28d. Describe how inj	
sic		cat	2 Accident investigation 3 Suicide 6 Could not be	7-9-04 7:22			JUMPED INTO RIVER
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	To the Hospitel or Attenwithin 24 hours after deat To the Sunerel Director: completely filled in by the	Medical		/sician: To the best of my knowledge, dea iner: On the basis of examination and/or i and manner stated.			
	o the ithin ; o the omple	Med	29b. Signature and title of certifier	and marrier stated.	29c. License number	29d. D	ate signed (Month, Day, Year)
	F ≱ F 8		1	hallago 1110	O.C.M.E.		July 10, 2004
			30, Name and address of person who d	ompleted cause of death (Item 23a) (Type			
			HARY SMT	1 KOREY			1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
	Sta	it ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	III Penn Stree	et, Baltimoi	re, Maryland 21201
	Regist		JUL 1 3 20	04 Beneva &	Spark		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** July 9:05 Raymond Lutz 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11 Ashford Court Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 100M 2□F Yrs Director 119-09-9308 84 August 8, 1919 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Marical Examinant or other traumatic event, the Marical Examinant or other traumatic event, the Marical Examinant or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ■Yes 2 No Director Marvland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 11 Ashford Court United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1**@**Yes 2 □ No If Yes, Give Year or Dates: 1939~1976 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify ð 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 4 accountant state government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Lutz Sus an Lee 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Ashford Ct. Annapolis, MD 21403 Marguerite Lutz/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Theresa's Cemetery July 19, 2004 Summitt, NJ ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Cancer Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) signed by the et 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funerei I
completely filled To the Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) title of certifier 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis, Md. 2140/

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
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			1 - For State Registrar	State	of Marylan		artmen			and Mo		giene Reg. No		238	200	
	Physici	an	1. Decedent's Name (First, Middle ANNA M. LARSON	9, Last)							2. Date of De. 7—05—		y ₄ Year		of Death	
	/Medic Examin		4a. Facility Name (If not institution	n, give street and πι	ım <i>ber)</i>		4b. City,	Town, or	Location o	of Death			. County of De		Р	
	de de la companya de la companya de la companya de la companya de la companya de la companya de la companya de		BERLIN NURSING				1	BERL				WORCESTER				
Ky.	Funeral Director		5. Social Security Number 094–24–4301	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 97	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da 06-09-]	th y, <i>Year)</i> L 907	9. Bi	rthplace (State Country) SWEDEN	or Foreign	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits	
	Maryl:	tor		MICO		SBURY									s 2 No	
	r 28a	Irec	10e. Street and Number	11100	DIIII	DDUKI	10f. Zip	Code				10g. Cit	izen of What C	Country?		
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	er dea	Funeral Director	11. Marital Status	Amed F		S. 13.	Was Deced	dent of His	spanic Orig n, Mexican	gin? (Spec	cify Yes or No- lican, etc.)	-	14. Race - Am Black, Wh			
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Maryland	should bailed and Mental Primarked of	To Be	KARL LARSON	2831/					HILM			IKNO				
ary		-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a					r Town, State,	Zip Code)		
	ロモトニ		DENISE WILSON -	NIECE					EEK C		-	ELD	VIRGIN	IA 221.	50	
Baitimore,	Pagas 1 and Dent of Healt of Healt of Healt out: If item 2 iry or other		20a. Method of Disposition 1 Burial	3 Removal from	State	lace of Dispo emetery, crer	natory or o	ther place	· 1	Da		20c. Lo	ocation - City or	r Town, State		
	parmit. Page Department Important: It any injury o		* 4 □ Donation 5 □ Other (S		CR	EMATOR'							LMAR, D		E	
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death									Approxima Interval Be	ate	
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ROX	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pr	acnancy				1	23d. Date of de	elivery	9	
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7.	requires that the de een signad by the a hould ba detached t	y Ph	Part II. Other significant condition	ons contributing to c	eath but not resu	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	se contribute t	o the cause of	death?	
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Š Š	Hospital or Attend 14 hours after daath Funaral Director: tely filled in by the	ertification;	3 Suicide 6 Could 4 Homicide	286. Place	e of Injury - At ho ing, etc. (Specify	me, farm, str	eet, factory	, office		28	If. Location (S City or Tow		d Number or R)	ural Route Nur	mber,	
_	To the Hospital or, within 24 hours after To the Funaral Dire completely filled in b.	O	29a, Certifier 1 28 Certifyin	g Physician: To the	best of my kno	wledge, death	occurred a	at the time	e, date and	place, an	id due to the c	ause(s)	and manner as	s stated		
	the Ho in 24 h the Fu npletely	Medical	(Check only 2 Medical one)	Examiner: On the b	asis of examination and stated.	tion and/or inv	estigation,	in my opi	inion, death	h occurred	at the time, d	late and	place, and due	e to the cause	(s)	
	vithii To II	Σ	29b. Signature and title of certifier	7	2 0 /	70	1	License					e signed (Mont			
			Triguru h	1. Bet	less	Min	. 1	D 2'	150	5	0	07-	-07-	2004		
0		4	6. Name and address of person GREGORIO M. [7]	who completed caused the second section of the second seco				PEY	Do	SAL	IC RUP V	V 14	י די חו	201		
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	•	For State Registrar	State of	Maryland / [rtment of F			ene	n L	23810
		Decedent's Name (First, Middle	e, Last)					2. Date of Death Month		Yeer	3. Time of Death
Physici /Medic		MARLIN L. LOR	D					July	11 2	2004	10:20 ₱M
Examin	er	4a. Fecility Name (If not institution					Location of Death			ly of Death Calbo	+
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Director		216-14-2726	1 X M 2□ F	81	Yrs.	Months Days	Hours Min.	AUG 11	1922	MARY	ĽAND
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ld be fental liked o	To Be	CHARLES W. LORI			HARRIETT FOSTER						
should and Men s marke turnatio	-	19a. Informant's Name/Relations	hip (Type, Print)	19b	. Mailin	g Address (Street	and Number or Rura	l Route Number,	City or Town	, State, Zip	Code)
and 2.		LISA L. MURPHY/	GRANDDAUGI				INGTON ST		N, MD	21601	
Pages 1 nent of H int: if Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from S			sition (Name of atory or other plac		ate 2	0c. Location	- City or To	wn, State
		4 □ Donation 5 □ Other (S21. Signature of Funeral Service		CHESAP		E CREMAT	ION CTR 7-	-12-2004	STEVE	NSVIL	LE, MD
permit. Departr Importa any inji		21. Signature of Purietal Service	MERC	50-			ELFENBEIN RISON ST I	& NEWNAN	ı Fune	RAL H	OME, P.A.
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/Medical Examiner		resulting in death)	Due to (c	or as a construence	of):	1.	1	./			2
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									ww/c/
uted d ansit	min	cause. Enter Undertying Cause (Disease or injury that initiated events	1	Mahare	lex	whice o	as dir	ماروع وم	in di	110	Vear
exec in an ial-tr	Еха	resulting in death) Last	Due to (c	or as a consequence	of):			2000	v - 611	1676	
ate be hysici the bu	lical		d								
The law requires that the death certificate be site has been signed by the attending physicia page 2 should be detached for use as the but	Physician/Medical	IF FEMALE:	23c If was outo	ome of pregnancy				inte	erdine nie		
atten atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bii	th 2 Fetal death		Ectopic pregnancy Other (specify)				ate of deliver onth	ny Day Year
t the d by the achec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno								
uires that the de signed by the a ld be detached f	by P	Part II. Other significant condition	ons contributing to de	ath but not resulting in	the un	derlying cause give	an in Part I.	23e. Did toba	icco use con	tribute to th	e cause of death?
w require been si should b	ted	criv	10/2 ev	lag f	X	flesh		1 Tyes	2 □ No	3 Proba	ably 4 Onknown
e 2 sh	Completed	all	NI A	MMill	2/	in		24a. Was an autopsy		prior to con	sy findings available appletion of cause of
n: The icate I								performe 1 ☐ Yes 2		death? 1 🗌 Yes	2 🗆 No
sician: The law s certificate has b lirector, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	patient 2 ER/Ou		oC and Othe	26. Place of Death				
g Phy er this ieral d	-	27. Manner of Death	28a. Date o	f Injury 28b. 7	Time of	3□ DOA 28c. Injury Work		ne 5 🗌 Residen 28d. Describe how)
andin ath. or: Aft	atio	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	gation	, Day Year) II	njury		Yes 2□No				
or Atth	27. Manner of Death 1—Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury M 28b. Place of Injury - At home, farm, street, factory building, etc. (Specify)						street, factory, office 28f. Location (Street and Number or Rural Route Num. City or Town, State)				Route Number,
n -=	29a. Certifier 1—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du										
pital Durs a eral [29a Certifier	a Physician: T. at	darst	death occurred at the time, date and place, and due to the cause(s or investigation, in my opinion, death occurred at the time, date an				se(s) and manner as stated. e and place, and due to the cause(s)		
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director;	edical (29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To the l Examiner: On the ba and mann	sis of examination an	death dorinv	occurred at the timestigation, in my op-	e, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	ise(s) and m e and place,	anner as sta and due to	ated. the cause(s)

Division of Vital Records, P.O. Box 68760,

State Registrar 30. Name and address of Person ROBERT SONO.
31. Date filed (Month, Day, Year) Person who completed cause of death (Item 23a) (Type, Print)

508

			For State Registrar	State	of Maryla		artment of F	lealth and M Death	•	giene Reg. NØ:	Ωl. '	23911
			1. Decedent's Name (First, Midd.	e, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physici: /Medic		Phillip N	latthew	Mend	doza			July		2004	0810 M
	Examin	er	4a. Facility Name (If not institutio	-		0	-	or Location of Death	,		nty of Death	
			PLNI N SULA KI. 5. Social Security Number	6. Sex	Med ICK	last birthday)	If Under 1 Year	If Under 24 Hrs.	O Data of Bird		LESMIC	
	Funeral Director		none Usual Residence of Decedent	1.XM 2□F	7. Age (III yis	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day July 7,		Mary.	ace (State or Foreign try) land
	laryland show		10a. State 10b. County		10c. C	ity, Town or Lo	cation				10	0d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rnust be rullfied at	Director	Maryland Worce	ster	Ber	clin						1 ☐ Yes 2 No
1	with the		10e. Street and Number				10f. Žip Code			10g. Citizen o	of What Count	try?
33	leath w	Funeral	P. O. Box 618	12. Was De	cedent Ever in l	J.S. 13. \	218] Vas Decedent of H		ecify Yes or No-	USA 14. B	ace - America	an Indian.
0 11/10	after dea or Items		1X Never Married 2 Mar	ried 1 Yes	2 □ No			dispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		lack, White, e	etc.
ENdoza IFFMM -0036	ours a	d by	3 Widowed 4 Divorced	If Yes, G Year or	Dates:		I ☐ Yes 2 ☐ No	Specify:		Spe	^{cify:} Wh	ite
15-6	filed within 72 hours after Hygiene. ther than "naturel", or Ite int, I're Medical Evariane	Completed	15. Deceder (Specify only highe	it's Education st grade completed	d)	(Give	lent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind of	Business/Ind	ustry
222	within iene. than	dmo	Elementary/Secondary (0-12)	College	(1-4or 5+)		N/A	5 /		N	/ n	
1867 br	0 - 0 9	Be C	17. Father's Name (First, Middle,	Last)		1	IV A	18. Mother's Name	e (First, Middle,		**	
77 ZZ 1	should be nd Mer ta marked	To E	Felipe Sar	Tiago	Mendo	za		Elizabet	_h	Α	Hoff	man
12. Ci.	2 s an is		19a. Informant's Name/Relations					and Number or Run			m, State, Zip (Code)
e, 7	s 1 and f Health item 27 other t		Elizabeth A. Ho	offman (r	mother)		 Box 618 sition (Name of 	B, Berlin	, Maryla Date		.811 n - City or Tov	un State
ام کری آت	Pages lent of I nt: If its ry or o		1 🗆 Burial 2 🛚 Cremation		n State	cemetery, cren	natory or other place	ce)				
E S	ermit. P epertme nportan ny njury nce.		* 4 □ Donation 5 □ Other (5		Sa	IISDURY	Name and Addre	ry July Funeral Ho	13, 200	1 Sal		, Maryland
B	Dep Imp any		won H	Olbre		50	ol Snow H	Hill Road	ome Proi . Salish	ession	larvlan Jarvlan	d 21804
	•		231. Pari 1. Enter the disease, o	complications that	t caused the dea						-	Approximate Interval Between
	Pnysician	i N	Immediate Cause (Final disease or condition	SIN	ere	non	e timi	try				Onset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a conse	quence of):		V				70
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	0 (01 40 4 001130	qualice oi).						
,	execun and ial-tra	Exal	that initiated events resulting in death) Last	C. Due to	o (or as a conse	quence of):						
760,	ate be executed obysician and the burial-transit	cal		d								
Box 68	leath certifica attending phi I for use as th		IF FEMALE:					· · · · · · · · · · · · · · · · · · ·				
X O	ath ce ttendi or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregrebinth 2 Fet	al déath 3 □	Ectopic pregnancy	у			Date of deliver	y Day Year
P.O. I	t the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre	gnant at time of known	death 5∟	Other (specify) _					,
	res that thigh and the igned by be detact		Part II. Other significant conditi	ons contributing to	death but not re	sulting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	bacco use co	ntribute to the	e cause of death?
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000	aw require is been siy 2 should b	plet							24a. Was		. Were autop	sy findings available
E R	The law cate has	Completed							autop perfor	med? 2 No	death?	pletion of cause of
ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medica examiner?					26. Place of Deat		/ -		
of C	Physic this o	은	1 ☐ Yes 2 XNo	Hospital:		ER/Outpatien		4 Nursing Ho				
	ding F h. After funera	lon	27. Manner of Peath 1 △ Natural 5 ☐ Pendi	ng (Mo	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injur Wor	ry at rk? Yes 2 □ No	28d. Describe h	ow injury occ	urred	
W/C Division	death death ctor:	ficat	3 ☐ Suicide 6 ☐ Could	nined 289. Plat	ce of Injury - At I	nome, farm, str	eet, factory, office	163 2 110	28f. Location (S	Street and Nur	mber or Rural	Route Number,
D is	tal or / rs after al Dire ed in b	Certification:	4 Homicide determ	buil	lding, etc. (Spec	ify)	. , , ,		City or Tow	rn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		Examiner: On the				me, date and place, ppinion, death occurr				
	To the To the comp	×	29b. Signature and title of certifie		-7		29c. Licens	se number	2	29d. Date sign	ned (Month, D	ay, Year)
			Muce	ell	10_		1.	24001		1//	010	4
			30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print) /AVA61	59827 11 51	SAL1361	ins	no	,
	Sta		31. Date filed (Month, Day, Year		Registrar's Sign	ature 4	Ann V	1	, ,	/ '		
	Registr	ar	JUL 1	2004	1	~	my vision					

Amend Item#17 State of Maryland / Department of Health and Mental Hygiene For per Fun. Dir. State of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Maryland / Department of Health a state of Department of Health a state of Department of Health a state of Department of Health a state of Department of Health a state of Department of Health a state of Department of Health a state of Department of Health a state of Department of Health a state of Department of Health a state of Department of Health a state of Department of Health a state of Department of Health a state of Health a Reg. No) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day mitchell **Physician** 2310 N 2004 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner po/13 JNINA PASANT Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 6 1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 6. Sex **Funeral** 217-52-2752 1 M 3 F 93 Director New Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location ral, or itema 23a or 28a-f show Examinst notal be notified at 10a, State 10d. Inside City Limits Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 56 Pleasant St. 21401 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: Black X Widowed 4 □ Divorced "natural" Completed other then "naturent, the Madical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th Homemaker None permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wesley Murphy Murphy Minnie Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Holland(Daughter) 1236 Kevin Rd. Baltimore, Md. 21229 Baltimore, 20b. Place of Disposition (Name of B & Set 660), crematory and the replace 1 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7-13-04 Annapolis, Md. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility Wm. Reese & Sons Mortuary, P.A. e MOD483821 West St. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** teriosalero /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): as the burialattending physician for use as the buris Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 Yes 2 No Division of Vital Physicien: tilled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 □ No Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After To the Hospitel or Attending 1 atural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) put4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nes, mo 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4	1	For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland		tificate of L			eg. No.	04	2 2 Q	Death
Physicia	an	Mala an	McLaughli	n			July 8,		Year	2:45	PM
/Medic Examin	_	Myrna Manon 4a. Facility Name (If not institution, give st		i	4b. City, Town, or	Location of Deatl)	4c. Cou	nty of Death	<u> </u>	
Examin	er	31867 Bonhill Driv			Salisbu	ıry		Wice	omico		
Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. Ia M 2 15 78	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8 Date of Birth (Month, Day April 1	Year)	Cour	place (State on http) yland	r Foreig
ž		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				1	lod. Inside Ci	ty Limit:
perint. Tages I and Salous before mainting in the second many of Health and Menial Hygiene important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	ţō	Maryland Wicomico	Sal	isbur	V					1 🗆 Yes	2 X N
r 28a	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Coul	ntry?	
23a o		31867 Bonhill Drive	<u> </u>		21804			U			
s E	Funeral	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	i. 13.	Was Dacedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	pecify Yes or No- o Rican, etc.)		łace - Americ Black, White,		
P E	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Spe	city: Wh	ite	
tural'		15. Decedent's Educ	ation	16a. Deced	dent's Usual Occup	ation		16b. Kind o	f Business/In		
n na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life.	kind of work done of DO NOT use retired	during most of wo d)	rking				
er the	EO.	12	4	Mark	eting Exe				rnment		
ad other event, II	BeC	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Sun		a	
and Ment marked umatic e	2	Edward	Mahon			Estell		City of To	Frati		
ls m		19a. Informant's Name/Relationship (Typ			ng Address (Street						
tealth om 27 har tr		Kyle F. McLaughlin 20a. Method of Disposition	-Daughter	3186	7 Bonhil.	I Drive,			218 on - City or To		
or of		1 ☐ Burial 2 【Cremation 3 ☐ R	emoval from State		sition (Name of matory or other place	Ta 1 37	9,2004				7
tment of rtant: If it njury or o	1	* 4 □ Donation 5 □ Other (Specify)			Cremato Name and Address	T Y	7,2004	Sali	sbury	, Mary	ıar
Department of Important: If any injury or once.		21. Signature of Funeral Service License	and ACES	P	olloway E Ol Snow E	Puneral	lome Prof	essio	nal As	sociat	:io
		23a. Part1. Enter the disease, or compli	cations that drused the death	. Do not ent	or the mode of dyin	ng, such as cardia	or respiratory are	est,	Maryla	Approximat Interval Bet	te
		shock, or heart failure. List only on Immediate Cause (Final	e cause on Fach line.							Onset and I	
nysician Medical		disease or condition resulting in death)	Adono Ca Due to (or as a consequ	1 Com o	-a of	wy				8 mo	-/
xaminer			200 (0 (0) 23 2 00 100 42	0.100 0.1,5	U						
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):							
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physician and s the burial-transit	cal		l								
ed by the attending phydetached for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnal	nev				224	Date of deliv	len.	
uttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3[Ectopic pregnancy Other (specify)	у		230.	Month	•	Year
the a	ysic	1 Yes 2 No	9 Unknown	aui St							
ed by the		Part II. Other significant conditions cor	stributing to death but not resu	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	bacco use	ontribute to	the cause of c	death'
sign d be	d by						1,80.3	es 2□N	o 3∏Pro	bably 4 □	Unkno
been si should l	Completed				***************************************		24a. Was		b. Were aut	opsy findings	availa
has je 2	E G						autop	med?	prior to co death? 1 Yes	ompletion of c	ause
		25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o	ne)	1 🗀 183	20110	
is certific director,	o Be	avaminar?	lospital: 1 Inpatient 2	ER/Outnatie	nt 3 DOA Oth		Home 5 esid		Other (Speci	ify)	
듣펻	H	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time (28d. Describe h			,,	
th. : After s funer	ig ig	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No					
@ - W	fica	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office	1	28f. Location (S City or Tox	Street and Ni m, State)	umber or Rui	al Route Nun	nber,
er death. rector: A by the fu	1 7		sician: To the best of my kno	wledge, dea	th occurred at the ti	ime, date and plac	e, and due to the curred at the time.	cause(s) and	d manner as	stated. to the cause(s	s)
hours after death uneral Director:	cal Certification;	29a. Certifier 1 Certifying Phy	nar: ()n the bacic of examinat						-		
nospital or 4 hours afte Funeral Dir tely filled in		(Check only 2 Medical Exami	and manner stated.			1		29d Data oi	aned (Month	Day Voorl	
To the Hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Certi	(Check only 2 Medical Exami	and manner stated.			1		29d. Date si	gned (Month	Day Voorl	
Hospital of 4 hours afte Funeral Dir tely filled in		(Check only 2 Medical Examione) 29b. Signature and title of certifier	and manner stated.			1		29d. Date si	gned (Month	Day Voorl	
4 hours afte Funeral Dir tely filled in		(Check only 2 Medical Examione) 29b. Signature and title of certifier 30. Name and address of person who come	and manner stated.	1 23a) (Type	29c. Licens	1	4. 5.	29d. Date si	gned (Month	Day Voorl	

		,	For State Registrer	State of Maryla	and / Dep					1001	23814
	0		1. Decedent's Name (First, Middle, Las	st)				2. Date of De	eath		3. Time of Death
	Physici /Medi		DAVID FRANKLIN					July	13,	2004	3:20 A M
	Examir	ier	4a. Facility Name (If not institution, give				n, or Location of Dea	th		County of Deat	
	Funeral		RAVENWOOD LUTHERA 5. Social Security Number 6. S		rs. last birthda) If Under 1 Ye				VASHINGT 9. Birt	DIN hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	®M 2□F 86	Yrs.	Months Day	ys Hours Mir	JULY 2,	191 191	.8 MA	RYLAND
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Moderal Examinational to mailthed at	ctor	10a. State 10b. County MARYLAND WASHING		City, Town or I	ocation	HAGERSTO	VN			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with th	Directo	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	
	eath v	eral	19603 NEEDY''S LAN	E 12. Was Decedent Ever in	US 13	Was Decedent of		742	n- T	U.S 14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or other traumatic evant. Ite Marical Extendible must be malified at once.	by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0.02	If Yes, specify C	of Hispanic Origin? (Juban, Mexican, Pue No <i>Specify:</i>	rto Rican, etc.)		Black, White	
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12	withii liene. r than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	1		'AL WORKER		SAND	BLASTI	NG EQUIP MFO
<u>ال</u>	e filec al Hyg otha vant.	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle			
<u>ya</u>	ould b Ments arked	10	EVERITT FRANKLIN				NINA O.				
Maryland	12 sh hand 7 is m traum		19a. Informant's Name/Relationship (ETHEL G. NEEDY/SP				eet and Number or F				
	1 and Healt tam 2		20a. Method of Disposition		. Place of Dis	osition (Name of	S LANE, H	AGERSION Date		IAK Y LAIND ocation - City or	
ē	Pages ent of nt: If ii		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif			ematory or other p L CEMETE	1	16/2004	НΔС	ERSTOWN	, MARYLAND
Baltimore,	permit. Departm Importa any inju		21. Signature of Fullegal Service Incer	See	- 1	22. Name and Add		7606 01	.d Na	tional Marylan	Pike
	i i	Г	23a. Part . Enter the disease, arcom shock, or heart failure. List only	plications that caused the de one cause on each line.						riaryran	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a cons		Stenos	· 'di				3 years.
	Examiner	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	sequence of).				_		
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8760,	ate be ex hysician the buria	cal		d							
Box 68	eath certifica attending ph for use as th	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred				7. 7		23d. Date of deli	very
	Q o Q	by Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown		☐Ectopic pregna ☐ Other (specify)				Month	Day Year
Franklin cords, P.C	es be		Part II. Other significant conditions of	ontributing to death but not r	resulting in the	underlying cause	given in Part I.			use contribute to	the cause of death?
Fra	- 9 to	letec						24a. Was			topsy findings available
David Franklin Vital Records, P.O.	i cian : The law certificate has b rector, page 2 sl	Completed						auto	psy ormed?	prior to death?	ompletion of cause of
		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	□ EB/Outpoti	ant 3 🗆 DOA	7	eath <i>(Check only</i> Home 5 - Resi		C Other (Spec	
NEEDY,	ding Phys h. After this funeral di	J-00	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year,	-	of 28c. In	Tiury at Vork? ☐ Yes 2 ☐ No	28d. Describe			ny)
NEED! Division	ipital or Attanding Phous after death. Baral Diractor: After the filled in by the funeral.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		t home, farm, s ecify)	street, factory, office	се	28f. Location (City or To			ral Route Number,
	To tha Hospital o within 24 hours af To tha Funaral Di completely filled in	edical C	29a. Certifier Certifying Ph (Check only one)	ysician: To the best of my k niner: On the basis of exam and manner stated.	knowledge, de ination and/or	ath occurred at the investigation, in m	s time, date and place by opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To tha Hos within 24 h To tha Fun completely	Me	29b. Signature and title of certifier				ense number			e signed (Month	
			Maujen	Isual			D2836	5	7-	- 13-09	
	X		30. Name and address of person who	T 56/ 1:	tem 23a) (Type	68 M10	el Striet	- Hagi	eveto	uru M.	02/742
:	St. Regist	ate .	31. Date filed (Month, Pay Year) 5	32. Registrar's Sig	gnature L	de sta		J		- Jp. / s	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2004 5:18A 0 Mary E. Owens July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Davidsonville 3585 Riva Rd. Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr 7 1912 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Maryland 1 □ M 2 1 F 213-32-4535 92 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a. State •how other then "natural", or Iteme 23a or 28a-f ehovent, the Medical Examiner roust be notified at MYes 2 □ No Maryland Anne Arundel Davidsonville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21035 3585 Riva Rd. USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify: Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education completed) College (1-4or 5+) Elementary/Secondary (0-12) Domestic 6th Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be to Department of Health and Mental Important: It item 27 te marked of any injury or other traumatic eve Mary Spriggs Ernest Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) √ames Hillary(Son) 3585 Riva Rd. Davidsonville, Md. 21035 20b. Place of Disposition (Name of Large Montage) a 1 20c. Location - City or Town, State 20a. Method of Disposition 7-16-04 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Davidsonville, Md. Gardens * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. eny ir ese M00483 821 West St. Annapolis, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence-of) **Examiner** lear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform has 2 No this certificate 1 Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death t Director: / d in by the f 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3306 of person who impleted cause of death (Item 23a) (Type, Print) Annapolis 888 Be51 arry5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JUL 15** Registrar

		1 - For Stete Registrar	State of M	laryland / Dep	partment of heartificate of	Health and N	lental Hyg	giene) n i.	220	1.0
		Decedent's Name (First, Middle	e, Last)				2. Date of Dea	ith	-Yans	3. Time of I	Death
Physic /Med		Ann D.	Ossman			·	Juny		, 2004	10:30	PM
Exam	iner	4a. Fecility Name (If not institution			4b. City, Town, o	or Location of Death Salisbury			omico		
Francis		Salisbury Nursi: 5. Social Security Number		ge (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	h	9. Birthp	lace (State or	Foreign
Funera Directo		218-16-5987	1 ☐ M 2 🖾 F	79 Yrs.	Months Days	Hours Min.	(Month, Day Septimeber			ryland	
puq *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation					0d. Inside City	v l imits
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r 28e-	Director	Maryland Wic	comico	Dalibu.	10f. Zip Code			10g. Citizer	of What Cour	itry?	
th witi	alD	227 Canal Park	Drive, #202		2180	04		USA			
er dea	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
irs after	by F	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give	<u>.</u> No	1 ☐ Yes 2 🔀 No	Specify:		Sp	ecify: W	hite	
LING X IX I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23e or 28e-f show event, I'ro Maulcul Expir, nar must be notified at	ted		nt's Education	16a. Dec	edent's Usual Occup re kind of work done	pation	cina	16b. Kind	of Business/Inc	dustry	
ithin 7	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-4or	/ife	DO NOT use retire	dding most or work	ung				
filed with Hygiene. other than		12 17. Father's Name (First, Middle,	Last) 2	Sec	retary	18. Mother's Nam	e (First, Middle,	State Maiden Su	Treasu	ry Dep	art.
ed is b	To Be			onoho		Goldie	Ann		Doughe	ertv	
2 should be and Menta is marked aumatic even	F	19a. Informant's Name/Relations			iling Address (Street						
Definition of wary to permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic process.		Pierre H. Ossm	nan (husban		Canal Par						2180
Pages 1 nent of He int: If iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from Stat	20b. Place of Dis	position (Name of rematory or other pla	ice)	Date	20c. Locat	on - City or To	wn, State	
Dallilli permit. Pag Department Important: any injury c		`4 ☐Donation 5 ☐ Other (5	Specify)	Marciela Mer	morial Cemet	ery July	13, 2004	Marc	ela Syri	ngs, Mar	yland
permit. Departr Importa	N N	21. Signature of Funeral Service	Licensee		22. Name and Addre						
		23a. Part1. Enter the disease, or	r complications that cause	ed the death. Do not e	501 Snow I				Maryla	Approximate Interval Betw	
Physician	- ii -	shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	00-m	16-	The state of	On of		4	Onset and Do	eath
/Medica	1	resulting in death)	Due to	a consequence of):	2	10	1 2 00		1 .		20
Examine		Sequentially list conditions,	b. Charles	- otors	culum	- Early	moren	. ~	creso	1 400	1-1
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ath cer attendir	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	y		23d	Date of delive Month		ear .
the de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time of death 5	Other (specify) _						
The law requires that the the has been signed by the page 2 should be detached.	by Ph	Part II. Other significant conditi	ons contributing to death	but not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use	contribute to th	e cause of de	ath?
w requires been sign							1 🗆 Y	es 2□N	o 3□Prob	ably 4 □Ur	iknown
taw requast been 2 should	Completed						24a. Was a		4b. Were auto	osy findings av	vailable use of
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OI VICAL FOR Physician: The Physician: The ribis certificate I ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		Ott	26. Place of Deal					
hy hy	1. To	1 Yes 2 No	28a. Date of In	jury 28b. Time	of 28c, Inju	ry at	ome 5 Residence 128d. Describe h		.,,	′)	
Attending Ph rr death. ector: After thi by the funeral	atlor	1 Natural 5 Pendii 2 Accident invest	(Adonth F	Day Year) Injury	Wo	irk?]Yes 2 □ No					
LIVISION C	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 200. Place of I	njury - At home, farm, : etc. (Specify)	street, factory, office		28f. Location (S City or Town		umber or Rura	l Route Numb	er,
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To the Hospitel or Attency within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifyi (Check only one) 1 Medical	ng Physician: To the best Exeminer: On the basis and manner:	of examination and/or	ath occurred at the ti investigation, in my	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and late and pla	d manner as st ce, and due to	ated. the cause(s)	
o the ofthin o the	Me	29b. Signature and title of certifie		oratios.	29c. Licens	se number	2	29d. Date si	gned (Month,	Day, Year)	
L > F 0		1000	Mhow		02	2/34	-9	7/	188	•	
		30. Name and address of person		f death (Item 23a) (Typ	e, Print)	Division	St Suit	G. Sa 1	ishury	. Md 21	1804
X		William Borins 31. Date filed (Month, Day, Year		strar's Signature			DC • DULL	.c/ba.	LODULY	, .14.63	.00-1
S Regis	itate strar	JUL 1		enera L	Spon	6					

		•	For State Registrar	State of Maryl		artment of H rtificate of		_	giene Reg. No. 0	14 23817			
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Edith S.	Pierr.	e			2. Date of De Month	13 a	Year ✓ 1:00 p M			
	Examin	er	4a. Facility Name (If not institution, give str 188 Inverness Road	eet and number)			or Location of Deat everna Pa		4c. County	of Death Anne Arundel			
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days			th	Birthplace (State or Foreign Country)			
и	Director		212-78-0071	1 2 X F	37 Yrs.	WOTHINS Days	TIOUIS IVIII.	July 2	23 , 1916	MN			
	72 hours after death with the Maryland netural; or Items 23a or 28a-f show order Examinar must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Arun	del 10c.	a Park		10d. Inside City Limits 1 ☐ Yes 25 No						
	r 28a	Irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?			
	23a c	aiD	188 Inverness Road				1146			USA			
Baltimore, Maryland 21215-0036	urs atter dez al', or items xamiliar m	by Funeral Director	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever i Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		Was Decedent of hilf Yes, specify Cub		Specify Yes or No to Rican, etc.)	Specil	ce - American Indian, ck, White, etc. fy: White			
	within ane. than	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	(Give	dent's Usual Occup kind of work done DO NDT use retire HOMEMA	during most of wo	rking	16b. Kind of Business/Industry Home					
	should be filed and Mental Hygis marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) James Swan			me (First, Middle, Leavitt	, Maiden Sumar	aiden Sumame)					
	s 1 and 2 should Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Leslie J. Pierre/			ng Address (Street Invernes							
	tem 2	1 3	20a. Method of Disposition	20	b. Place of Dispo		1	Date		- City or Town, State			
	Pages nent of int: if it		1 ☐Burial 2 ☐ Cremation 3 ☐ Rei 1 ☐ Donation 5 ☐ Other (Specify)	noval from State		en Cemet	ery Jul	Ly 17, 2004	Glen H	Burnie, MD			
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Serv. e Licenso	er sone	2 B	Name and Address arranco d 95 Gov. I	ess of Facility & Sons, I Ritchie I	P.A. Seve Hwy, Seve	erna Pai erna Pai	rk Funeral Home rk, MD 21146			
Records, P.O. Box 68760,	Physician and with price of the	ical Examiner	Shock, or heart failure. List only one cause on each line. Interval Between on Consett and Death (Island State of Condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		□Ectopic pregnanc	у		1	23d. Date of delivery Month Day Year				
	quires that n signed b uld be deta	þ	Part II. Other significant conditions conti	ibuting to death but not	23e. Did t		tribute to the cause of death? 3 Probably 4 Unknown						
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Vital	Physicien: Trithis certificat	Be	25. Was case referred to medical examiner?	spital:	200	ath (Check only one)							
of	ith. : After this e funeral dir	ation: To	1 Yes 2 No 100 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28 ER/Outpatie 28b. Time of Injury Injury		nt 3 DOA 4 Nursing			dence 6 ∐Ot/ how injury occui	6 Other (Specify)			
Division	tel or Attending is after death. el Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28f. Location (Street and Number City or Town, State)			ber or Rural Route Number,						
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical	29a. Certifier (Check only one) Certifying Physical Examine	cien: To the best of my or: On the basis of exar	knowledge, deat nination and/or in	h occurred at the tr vestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	anner as stated. and due to the cause(s)			
L.	To the within To the comple	Me	29b. Signatule and title of certifier	29c. License number			29d. Date signed (Month, Day, Year)						
,			30. Name and address of person who com	pleted cause of death	(Item 23a) (Type,		35611	1 1		5-04			
			30. Name and address of person who com Tra E. Kaplan 31. Date filed (Month, Day, Year)	845 Daki	ionatura	1 #300 l	den Bui	mie, p	larylar	U 21061			
	Sta Regist		JUL 1 6 20	32. Figistrar's S	J. J.	book							

Please Type or Print in Black indelible ink. Ensure All Copies Are Legible. John R. Purdy IV 04 - 4770Amend Item #17 tate of Many land Department of Health and Mental Hygiene **AKG** Certificate of Death 8/12/04 tasses No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Dav **Physician** John R. Purdy IV July 22 2004 6:38 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rawlings 23909 McMullen Highway Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/28/63 Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**⊠**M 2□F 40 Yrs. 216-82**-**7974 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f shor MD Allegany Rawlings 1 ☐ Yes ŽŽNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21557 U.S.A. 23909 McMullen Highway Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Exal-liter. filed within 72 hours after 1 Never Married 2 Married Baltimore. Maryland 21215-0036 ō 1 □ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☑ Divorced er than "natura". Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Salesman Safety equipment other 17. Father's Name (First, Middle, Last) John R. Purdy III 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental Donna Kephart is marked 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23909 McMullen Highway, Rawlings, MD 21557 Donna Purdy/mother itam 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Scarpelli Crematory 7/26/04 Cresaptown, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Markwood Funeral Home, Inc. Box 912, Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Narcotic Intoxication resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or income Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) I Yes 2 □ No o the 9 Unknown þ ۵ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an page cate 2 ☐ No 1 Yes of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5□ Residence 6 QOther (Specify) at scene P 1XXYes 2 ☐ No 28a. Date of Injury **Fourma**h, Day Year) **7/22/04** 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division To the Hospital or Attanding Found 5:30 1 Natural 5 Pending death. 1 Yes 2 No Unknown investigation a M 2 Accident Director: 6X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found at Residence 28f. Location (Street and 3909) Renal Royal Number How 4 - Homicide at Residence thin 24 hours a tha Funaral C Rawlings, Maryland 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 O.C.M.E. July 23, 2004 ress of person who completed cause of death (Item 23a) (Type, Print) SIL 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of Ma	ryland / Dep		t of H	ealth a		lental Hyg	Reg. No. ()		23819		
	Physicia	an	1. Decedent's Name (First, Middle, Last) Christopher Leo Rooney 2. Date of Death Month Day Year July 14, 2004 6:20												
5	/Medic	al	Christopher Le			4h City	Town or	Location	of Death	Jury		2004 6:20 P M			
1	Funeral Director	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis								Anne Arundel				
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date									th 9. Birthplace (State or Foreign Country)			
			579-04-0106 37 Yrs. Usual Residence of Decedent								67		ryland		
		_	10a. State 10b. County		10c. City, Town or Lo								10d. Inside City Limits 1 Yes 2 □ No		
	the M	Director	Maryland Prince (George's	Bowie	10f. Zip	Code				10g. Citizen of	What Cou			
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Maulical Examera in the modified at						20716	5			USA		,		
		Funeral	15100 Nighthawk In. 20/16 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								ce - Ameri				
36	rs after	by Fu	1 Never Married 2X Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 2 X No			1 ☐ Yes 2 No Specify:					Specify: White		
9	r2 hou	To Be Completed b	15. Decedent's Education 16a. Decedent's Usual Occupation							ing	16b. Kind of Business/Industry				
21	within 7 iene. 'then "r		(Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired) [Give kind of work done during most of working life. DO NOT use retired)							David	Printing				
22	e filed wall Hygier ti		17. Father's Name (First, Middle, Last)	1 years	Sa.	les Di	rect		er's Name	e (First, Middle,			3		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 ho I to Health and Mental Hygleine. If item 27 Is marked other than "nature or other traumatic event, I'te Maufical		Mharra D. Dannara								Bayer	yer			
Aary	2 should be and Menta Is marked raumatic sv		19a. Informant's Name/Relationship (T)							al Route Numbe			Code)		
a)	is 1 and 2 of Health item 27 I		Kimberley L. Roone 20a. Method of Disposition	ey/ Wife	20b. Place of Dispo	sition (Nan	ne of		ane,	Bowie,	MD 207		own, State		
mor	Pages ent of nt: If it ry or c		1 Burial 2 Cremation 3 II		Kalas Cı	* .			7–17	-04	Edgewa	ter,	MD		
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signatur y Funeral Service Licens								Kalas	Funer	ral Home 1D 21037		
	at the death certificate be executed By the attending physician and mached for use as the burial-transit		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused to one cause on each line	9.					or respiratory ar	rest,		Approximate Interval Between Onset and Death		
			disease or condition resulting in death) a. Vulmonary Embolism										nours		
B				Due to (or as a consequence of):											
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):											
		Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
760,		calE	d												
.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal death 3 [⊒Ectopic pr ⊒ Other <i>(sp</i>						23d. Date of delivery Month Day Year			
s, P	res tha igned be de	Completed by Pr	Part II. Other significant conditions contributing to death out not resulting in the uncertying cause given in rank							23e. Did to	he cause of death?				
Record	The law requi		24a								/ks an utopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death?				
Vital	Physicien; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Cth	OF:		(Check only o					
of	Phys rthis ral di	. To	1 ☐ Yes 2 🔏 No 27. Manner of Death	28a. Date of Injury	y 28b. Time o		JA	4 🗀 NU	-	me 5 ☐ Resid 28d. Describe h			y)		
ion	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	atior	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No												
Division		edical Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm, st . (Specify)							at and Number or Rural Route Number, State)			
	To the within To the Comp	Me	V	Mech, M			D	ubos			29d. Date sign	ed (Month,	Day, Year)		
			30. Name and address of person who of Siverol Bech,	completed cause of de	eath (Item 23a) (Type 1 eolical Pon	Print) Way	an	napel	is, t	ıD					
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 6 2	32. Pogistra	r's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) Дм Donald Walter Ross July 2004 6:00 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 912 Ravens Head Hill Sherwood Forest

Funeral Director

Physician

/Medical

Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "neturel", or items 23e or 28e-1 show eny injury or other treumatic event, I'm Marical Exp. infer matice rolling at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeref Director: A completely filled in by the fi

Division of Vital Records, P.O. Box 68760,

	5. Social Security N	umber	6. Sex 1 X ONL 2 □ F	7. Age (In yrs	e (In yrs. last birthday)		Months Days		Min.	8. Date of the (Month, i	, Day, Year)		COL	intry)	
	213-26-3	3781	LOUIN ZLIF	72	Yrs.					Oct.	13, 1	931	New	v York	
	Usual Residence of	Decedent													
	10a. State	10b. County		10c. C		:. City, Town or Location								10d. Inside City Limits	
ţō	Maryland	Anne	Arundel			Sherwood Forest							1 ☐ Yes		
e e	10e. Street and Nur	mher				10f. Z	ip Code				10g. Ci	tizen of	What Cou	untry?	
Ω	912 Rave				.,	214	05			U.S.A.					
lera	11. Marital Status	cedent Ever in t	ver in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							14. Race - American Indian,					
Fur	1 Never Marr	Forces?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								Black, White, etc. Specify: White				
d by	3 🗆 Widowed	Dates: 1948	1948–60 1□Yes XX No Specify:												
Completed by Funeral Director	(Spec		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (16b. Kind of E								usiness/li	ndustry			
ошо	Elementary/Seco	(1-4or 5+)	Sales Manager Automotive After									Aftermarket			
O	17. Father's Name	(First, Middle,	Last)					18. Mothe	er's Nam	e (First, Midd	ile, Maider	n Sumar	ne)		
To Be	Walter He	enry Fr	ederick 1	Ross				Evel	.yn Z	Annett	Cuts	ail			
-	19a. Informant's N					•				ral Route Nun					
	Dorothy	7 Ross/	wife		912 R	aven	s Head	l Hil			-			21405	
-	20a. Method of Dis		20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City							- City or T	Town, State				
	` 4 □Donation				Baltimore Crematory 7/12/2004 Ba										
	21. Signature of Funeral Service License: 22. Name and Address of Facility John M. Taylor Funeral Home														
	1/601	JUh.	Slam									mapo	olis,	MD 21401	
	23a. Part1. Enter t shock, or hea	he dease, o art failure. List	r complications that t only one cause or	lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Battween on each line. Approximate Interval Battween on each line.											
	Immediate Cause disease or condition	(Final	L	ung Cano	cer									Onset and Death 1 vear +	
	resulting in death)	211	a. Due t	Due to (or as a consequence of):										1 year 1	
	Cognostially list on	nditions	b	b											
iner	Sequentially list confirmed in any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying	Due t	Due to (or as a consequence of):											
cam	that initiated events resulting in death)	5	c	c											
e E	,														
dic	Due to (or as a consequence of):														
/Me	IF FEMALE:		23c. If ves. o	outcome of pregi	nancy	23d D							ate of delivery		
ian	23b. Was deceder in the past 12	months?	1 ☐ Live	birth 2 Fe								Month Day Year			
ysic	1 Yes 2 No 9 Unknown 9 Unknown														
l P	Part II. Other signi	ficant conditi	ons contributing to	death but not re	sulting in the u	inderlying	cause give	n in Part I		23e. Di	d tobacco	use con	tribute to	the cause of death?	
d b	Chronic Obstructive Lung Disease											bably 4 Unknown			
ete	24a. Was an 24b. Were autopsy findings available											toney findings available			
					autop						osy prior to completion of cause				
Comp	1 Yes 2 XNo 1 Ye											1 🗆 Yes	2 No		
Be	25. Was case refe examiner?	rred to medica			26. Place of Death (Check only one)										
10	1 ☐ Yes 2 ☐	No	Hospital:	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🔀 F						ome 5🔼 Re	Residence 6 Other (Specify)				
ion:	27. Manner of Dea	5 Pendi	ng (M	te of Injury onth, Day Year)	28b. Time o Injury	Injury Work? M 1 ☐ Yes 2 ☐ No					Describe how injury occurred				
cat	2 Accident 3 Suicide	invest 6 🗆 Could	not be		home for-						28f. Location (Street and Number or Rural Route Number,				
Certification:	4 Homicide		nicod 289, Pla	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
Ö	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										stated.				
dicai	(Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											to the cause(s)		

Me

State

Registrar

29b. Signature and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert T. Peterson, MD

JUL 12

31. Date filed (Month, Day, Year)

strar's Signature

29c. License number

D 24804

2001 Medical Parkway Annapolis, MD 21401

29d. Date signed (Month, Day, Year)

July 12, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name /First Middle Last Day Month Vaa REFDER **Physician** 7:30 APPL 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner MOSLINGTO WOSH, NSTON Cty HOGEISTOWN If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months 1**∏**M 2□ F Yrs Director 67 Dec. 20,1936 Pennsylvania 171–28–7900 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28e-f show Examiner must be notified at 1 Yes 2 □ No Directo Maryland Washington Co. Hagerstown the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò Items 23a U.S.A. 145 Sunbrook Lane 21742 Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. l ⊠Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: "naturel", Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Anesthetist Health Care Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental H Pages 1 and 2 should nent of Health and Men 2 Robert E. Reeder Wiona L. White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 21742 Alma Monique Reeder/ Wife 145 Sunbrook Lane Hagerstown, Maryland other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Importent: If its any injury or or once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory Jul 17,2004 Smithsburg, Maryland A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funer I Service Licenses 23a. Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u> 1331 Eastern Blvd. N. Hagerstown, M</u>D Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HADOXIN /Medical Du o (or as a consequence of): **Examiner** PNEUMONIO Sequentially list conditions, if any, leading to immediate cause. Ente, Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-translt JOSTALIC Due to (or as a consequence of): Box 68760, physician Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year ξō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 99 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 21 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ☐ Yes 2 ER/Outpatient 3 DOA Certification: To npatient 1 this anner of 💈 ath (Month, Day Year) 27. 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Thomicide 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical To the Hos within 24 ho To the Func 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2H- 26+1 120530

Registrar

State

30. Name and address of person ---- moleted

death (Item 23a) (Type, Print)

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32. Registrar's Signature

4.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Eleanor J. Reiter Ju1y 7:46P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. Joseph Richey Hospice Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Aug. 22, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 💢 F 511-12-7282 81 Yrs. Director Kansas Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "naturel", or Items 23a or 28a-f show dical Examiner must be notified at 1.□Yes 2 □ No Director Delaware Sussex Rehoboth Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
ent: if item 27 is marked other than "naturel; or items 23a or ;
ury or other traumatic event, the Medical Examinat must be or 12 Deerfield Lane USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer Wilev ٩ Eleanor Neso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan LoBiondo / Daughter 12 Deerfield Lane, Rehoboth Beach, DE 19971 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Department of H Importent: If ite any injury or ot once. Eastern Shore Crematorium July 6, 2004 1 4 ☐ Donation 5 ☐ Other (Specify) Lewes, DE 21. Signature of Emeral Service Licen 22. Na Parsello Funeral Homes & Crematorium 1449 Kings Highway, Lewes, DE 19958 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia Pnysician lyear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□ Unknown 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2000 death? 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DZ4170 July 6, 2004 150

State Registrar

DHMH 17 Rev 1/2001

838

N. Eutan St Balfimore, MD 41201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ichey Hospice

82. Registrar's Signature

SO MD

JUL 0 8 2004

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3: Time of Death Dav Month Year **Physician** 8:36 AM Robert Milton Reichard July 14 /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16830 Tammany Manor Road Williamspor Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1**X** M 2□ F 80 Director 219-12-0189 Oct. 21, 1923St. James, MD. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Examinat must be notified at 1 ☐ Yes 🏋 📉 No Director MD Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.

14. Race - American Indian, 16830 Tammany Manor Road Funerai 21795 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. is 1 and 2 should be tiled within 72 hours after of Health and Mental Hygiene. 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ş 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) Cable Splicer Telephone Co. 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rev. J. Rowland Reichard Mary Katherine Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16830 Tammany Manor Rd. Williamsport MD. 21795.
Place of Disposition (Name of Date 20c. Location - City or Town, State Dorothy Reichard - spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ital
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) July15,2004 Smithsburg, MD. Smithsburg Crematory
22. Name and Address of Facility 21. Signature of Funeral Service Licensee Donald Edwin Thompson Funeral Home, Inc. Keucho Kelny 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode or lying, such as caldidad & aspirato Daries, ng, MD. shock, or heart dilure. List only one cause on each line. Arrivate de Immediate Cause (Final Priysician COCODARY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** erebra vascular accident superially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 menths?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Ď 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 1 Yes 2 No To the Hospitat or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٢ After the 27. Man of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t determined 4 / Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Mghth, Day, Year) 0056375 04 Campus Rd Hagerstown 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Jo Teresa 11110 Medical 31. Date filed (Month, Day Year) 16 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year July 14, 2004 Barbara Smith 2:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3110 Gracefield Rd. #320 Montgomery Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 F Months Hours Min. 217-26-1024 73 Director March 15, 1931 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "netural", or items 23a or 28a-f show treumatic event, it is Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3110 Gracefield Rd. #320 20904 United States death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - Americen Indian Black, White, etc. e filed within 72 hours after d. It Hygiene. other than "netural" or Item 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien. Importent: If flem 27 is marked other the any injury or other treumeric tax officer
18. Mother's Name (First, Middle, Maiden Surmame) state government 17. Father's Name (First, Middle, Last) Robert A. Basil Marie Bembe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3110 Gracefield Rd. #320 Silver Spring, MD 20904 of Disposition (Name of Date Date Joseph Smith/ husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 € Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery July 19, 2004 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician secondary leukemia months /Medical Due to (or as a consequence of): Examiner cobalt therapy and chemotherapy with nitrogen mustard decades Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? certificate 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide after To the Hospital within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) D34590 reel July 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy Fried, MD 3110 Gracefield Rd. Silver Spring, MD 31. Date filed (Month, Day, Year) histrar's Signature State 1 6 7004 1999 Registrar

			1 - For State Registrar	te of Maryland / Dep	artment of Health and Martificate of Death	1ental Hygid	_
	Physici	an	1. Decedent's Name (First, Middle, Last) Marjorie Christine S	Corrolls		2. Date of Death Month July	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Death	July	13, 2004 6:45 a M
	Exami	iei	Anne Arundel Medical		Annapolis		Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 577–32–8029 1 □ M 25 Usual Residence of Decedent	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Apr. 20,	9. Birthplace (State or Foreign 1928 NC
	yland now		10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits
	e Mar ia-fsh liffed	ctor	MD Worcester	`	Eden		1 ☐ Yes 2127 No
	23a or 28	al Dire	10e. Street and Number 14568 Foltz Dr., P.C	. Box 105	10f. Zip Code 21822	10g	g. Citizen of What Country? USA
9800	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or Items 23a or 28a-1 show event. I'ra Medical Era offer minst be rediffed at	d by Funeral Director	1 Never Married 2 Married 1 If You	Yes 2X No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
15-("natu	ietec	15. Decedent's Education (Specify only highest grade comp.	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/Industry
72	e filed within al Hygiene. I other than ' vant, tra Me	Completed	Elementary/Secondary (0-12) Coll		Unit Secretary		Hospital
Maryland 21215-0036	2 should be filed nand Mental Hygin Is marked other reumetic event.	To Be C	17. Father's Name (First, Middle, Last) Harvey N. Wynn			(First, Middle, Ma Turner	
, Mary	and 2 sho salth and I n 27 Is ma	19	19a. Informant's Name/Relationship (Type, Prin Carol Gould/Sister		ng Address (Street and Number or Rura 9 Hampton Road, An	napolis,	City or Town, State, Zip Code) MD 21401
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumetic e once.	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State 20b. Place of Disponsion State Fort Line		1.	c. Location - City or Town, State Brentwood, MD
Balt	permit. Depart Import any inj		21. Signature of fluneral Service Licensee	22 811 CO 49	95 GOV. Ritchie Hw	y, Severr	
	°nysician /Medical		resulting in dealin		er the mode of dying, such as cardiac co		Approximate Interval Between Onset and Death
8760,	ate be executed EX Hysician and Interpretation and	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.	ue to (or as a consequence of): ue to (or as a consequence of):			
.O. Box 6	Attanding Physician: The law requires that the death certificate be executed redeath. The telesth is certificate has been signed by the attending physician and ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing	g to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death?
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Ĭ	sicial s certifirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital:	15	26. Place of Death	10105 550	
Division of Vital	nding Phys tth. :: After this e funeral di	\vdash	27. Mann eath 28a.	1 ☑npatient 2 ☐ ER/Outpatien Date of Injury (Month, Day Year) 28b. Time of Injury	4 Nursing Hon	ne 5 ☐ Residence 8d. Describe how i	e 6 Other (Specify) njury occurred
É	ial or Atta s after des al Director ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of Injury - At home, farm, strebuilding, etc. (Specify)	eet, factory, office	8f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only Z Medical Examinet: On	o the best of my knowledge, death the basis of examination and/or inv manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	Yot With Tot com	Σ	29b. Signature and title of certifier	ww.	29c. License number D \$\phi\$ 58 237	29d.	Date signed (Month, Day, Year)
			30. Name and address of person who completed Apphen G. Shaw, M.D.	cause of death (Item 23a) (Type, I Anne Arundel M	1: 6	innapolis	MD 21401
200	Sta Registra	_	Tr. Chr. co.	32 egistrar's Signature	with the same of t	(),	,

			1 - For State Registrar	State	of Maryla		artment of H		and Me			0.01		
			Registrar 1. Decedent's Name (First, Middle	o (act)		Cei	tinicate of t	Dealli		2. Date of De	Reg. No.	104	231	3.26
н	Physici	an	JAMES ALBERT		n					Month	Day	Year	3. Time	12 DM
	/Medic		4a. Facility Name (If not institution				4b. City, Town, or	1 coation o	of Dooth	July	12	2004 ounty of Death		· • • • • • • • • • • • • • • • • • • •
	Examin	er	Stella Maris Ho		umoury		Baltimor		Death		40.00	ounty of Death	1	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birt	th	9. Birth	place (Stat	e or Foreign
	Director		523-44-4453	1 ⊠ M 2□F	69	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)		lorado	e or Foreign
	P.		Usual Residence of Decedent										TOTAGE	
	show	_	10a. State 10b. County		10c. (City, Town or Lo	cation						10d. Inside	
	Sa-f	Director		Arundel		Edg	ewater							es 2 X No
	with ti		10e. Street and Number				10f. Zip Code				10g. Citizer	n of What Cou	intry?	
	s 234	eral	959 Mayo Rd.	10 Wee De		11.0	21037		. 0.40		USZ			
	iten de	Funeral	11. Marital Status 1 □ Never Married 2X Mar	Armed F		0.5.	Was Decedent of Hi f Yes, specify Cuba	ispanic Oriç in, Mexican	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)	- 14.	Race - Amer Black, White	ican Indian, , etc.	
336	irs af	by F	3 ☐ Widowed 4 ☐ Divorced	167	2 □ No live Dates: 196	2-95	1 ☐ Yes 2X No	Specify:			Sp	pecify: W	nite	
ŏ	within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-1 show ha Madical Examiner must be collified at	ted	15. Deceder	t's Education		16a. Deced	lent's Usual Occupa	ation			16b. Kind	of Business/I	ndustry	
21215-0036	thin 7	ple	(Specify only highe Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	kind of work done of OO NOT use retired	during most)	of working	g				
	ygien Per th	Completed		5+		Vet	erinariar					rinary	Medic	cine
nd	be fill tal Hy d oth	Be	17. Father's Name (First, Middle,		_			18. Mothe		(First, Middle,		mame)		
Maryland	ould Men parke	^o	James Leit		rd					dys Wi				
Mar	12 sh h and 7 Is m rraum		19a. Informant's Name/Relations Patricia D. Stu		ifo		Marzo Pd						p Code)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be collified at ODGs.		20a. Method of Disposition	unara, w.			Mayo Rd.		Jewa Le			ion - City or T	own State	
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Ba	Depi Impo		1/1/4/1/1/1	11/02			Name and Address Solom							
			23a. Part1. Enter the disease, or	complications that	caused the de							icer, N	Approxim	ate
	Pnysician		Immediate Cause (Final	only one cause on	each line.	1				,			Interval B Onset an	
	/Medical		disease or condition resulting in death)	a Due to	(or as a conse	equence of):	2 000	w						
	Examiner				,	4								
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Ö,	e exe		resulting in death) Last	Due to	(or as a conse	equence of):								
8760,	tificate be executed g physician and as the burial-transit	edlcal		d										
9	ding p		IF FEMALE:	220 If you or	steems of ores									
Вох	attendation	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live	itcome of preg birth 2 □ Fe nant at time of	ital death 3	Ectopic pregnancy				23d.	Date of deliv Month	ery Day	Year
Р. О.	the d	yslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unki		004(11 5	Other (specify)							
	The law requires that the death certif te has been signed by the attending bage 2 should be detached for use a	y Ph	Part II. Other significant condition	ons contributing to	death but not re	esulting in the ur	iderlying cause give	n in Part I.		23e. Did to	bacco use	contribute to	he cause of	death?
Vital Records,	quires n sigr	d by								1 🗆 Y	es 2 N	o 3 Pro	bably 4	Unknown
000	w require s been sign should b	lete								24a. Was a	an 24	4b. Were auto	psv finding	s available
Re	The lav te has age 2:	Completed					· .			autop: perfor	sy med2	prior to co death?	mpletion of	cause of
<u>ra</u>	yslcian: The is certificate hadirector, page	a)	25. Was case referred to medica					26. Place	of Death /	1 ☐ Yes Check only or		1 🗆 Yes	2 🗆 No	
<u>></u>	iysici is cel direc	To B	examiner? 1 ☐ Yes 2 ZNo	Hospital: 1	Inpatient 2[☐ ER/Outpatien	t 3□ DOA Othe			9 5 ☐ Resid		Other (Specia	w hirs	oice
Division of	ng Ph ter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28	d. Describe h				Acc
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	urs et													l.
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; g	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To th Examiner: On the I	pasis of examin	nowledge, death nation and/or inv	occurred at the tim estigation, in my op	e, date and inion, death	d place, an h occurred	d due to the c Lat the time, d	ause(s) and late and plac	d manner as s ce, and due t	tated. o the cause	(s)
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	F 3 F 8		Dr W	$\sim \chi$					85		_	1 1	MOON	
			30. Name and address of person	who completed cau	se of death (Ite	em 23a) (Type. I	Print)	9 (0	, 5 ,			, , , , , ,		
				sebers	<u> </u>	SI ST	PAUL P	1 Ba	Him	ore r	nd.	212	-02	
-6	Sta	- 4	31. Date filed (Month, Day, Year)		sistrar's Sign		1							
	Registr	ar	JUL I	6 2004		D- A	2306							

			For State Registrar	State of Ma	rylan		artment					giene Reg. NG)	001	000	
	Physica /Medi		1. Decedent's Name (First, Middle, La	. Sher	m	AN				2.	Date of Dea Month		200°	3. Time.	5 8 M
	Examir	ner		idel Gen		esp p	4b. City, T	INA	Location of	poli	S Date of Birth		county of Dea		
	Funeral Director		218-96-5513 Usual Residence of Decedent	1 Q M 2□F	41	Yrs.	Months	Days	Hours	Min.	(Month, Day	, Year)	Co	thplace (State ountry) MD	or Foreign
	e Marylar 8a-f show	ctor	MD 10b. County Anne	Arundel	10c. City	y, Town or Lo		dgew	ater					10d. Inside (City Limits s 2 ☑ No
	with th	Funeral Director	10e. Street and Number 827 Mayo Road, A	\n+ 22			10f. Zip (25		1	10g. Citize	on of What Co	ountry?	
	death	erai	11. Marital Status	12. Was Decedent E	ver in U.	S. 13. \	Was Decede	210 ent of His		gin? (Specif	v Yes or No-	14	USA I. Race - Ame	nican Indian.	
5-0036	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show dical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 [文]N If Yes, Give Year or Dates:		ł	fYes,speci 1 □ Yes 2		Specify:		y Yes or No- an, etc.)		Black, White Specify:		
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lary	d 2 should th and Men 7 Is marke traumatic	_	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	er or Rural R	oute Number	r, City or 7	Town, State, 2	Zip Code)	
	s 1 and if Health item 27 other tr		Dorothy Siders/ 20a. Method of Disposition	Sister	20h P	lace of Dieno	cition (Nam.	a of		rive, N	Woodbi			797	
Baltimore,	Page nent c ant: If ary or		1 ☑ Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Speci	fy)	CE	adowric	natory or oth dge Me	her place em. I	Park	July 20	14, 004	Elkı	ridge,	MD	
Ba	permit. Departr Imports any inje		21. Signature of Juneral Service Lice	Ille		7.	22 601	. 1	r ccitt	e nwy	, seve	Illa I	Park Fr	uneral D 211	46
	Discontinuo		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line	the death				, such as	cardiac or re	spiratory arr	est,		Approxima Interval Be Onset and	tween
	Physician /Medical		disease or condition resulting in death)	a. / 44 p0 Due to for as a	consequ	ence of):	nrA								
	Examiner		Sequentially list conditions,	. Insul	10	De	PEN	den	47	DIA	bet	45			
	rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Calculated Triping	Due to (or as a	consequ	uence of):	,								
o,	ate be executed hysician and the burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or as a	consequ	uence of):									
8760,	ate hy: the	dicai		d			_								
O. Box 6	at the death certifice by the attending phates tached for use as to	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at to 9□Unknown	2 ☐ Fetal	death 3	Ectopic pre Other (spe					230	d. Date of del Month		Year
rds, P.	es tha igned be de	leted by Ph	Part II. Other significant conditions	contributing to death bu	t not resu	ulting in the ur	nderlying ca	use giver	n in Part I.		23e. Did tol	ad.		the cause of o	
Vital Record	The law ate has b page 2 sl	Complet									24a. Was a autops perform	iy	24b. Were au prior to death?	topsy findings completion of c	available cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	٠			Other	-		heck only on				
of		n: To	1 Nes 2 No 27. Manner of Death	28a. Date of Injury	,	ER/Outpatien 28b. Time of		c. Injury	4 Nu		5 Reside		Other (Spec	cify)	
ion	Attanding r death. ector: After by the fune	atio	1 ANatural 5 ☐ Pending investigation		Year)	Injury	М		? es 2 □ h	No					
Division	ital or Attandrs after deathral Director: led in by the	Certification;	3 Suicide 6 Could not to determined	28e. Place of Injurbuilding, etc.			eet, factory,	office		28f.	Location (St City or Town		Number or Ru	ral Route Num	nber,
	To tha Hospital or At within 24 hours after or To tha Funaral Direct completely filled in by	ledical	(Check only one) 21X Madical Exa	hysician: To the best of miner: On the basis of and manner state	examinat	wledge, death ion and/or inv	occurred at restigation, i	t the time in my opi	nion, deat	d place, and th occurred a	due to the ca	ause(s) ar ate and pl	nd manner as ace, and due	stated. to the cause(s	6)
)	Nith To	Σ	29b. Signature and title of certifier	Par	Sep) D		License		054	1	9d. Date s	signed (Mont)	n, Day, Year)	
			30. Name and address of person who	. JON	05p	D	Print)	15	An	nevi	LA	i	310	35	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 13	2004 32. Figistral	r's Signat	b A	meter	•							

38760,	
Box 6	
P.O.	
Records,	
Vital	
of	
vision	

			For State	Please	Type or Prin State of Ma		Depa	ırtment	of H	lealth and M	-		_	
			Registrar	ima Adiabata Cas			Cer	tificate	ot i	Death	2. Date of D	Reg. No	2004	23828
	Physici /Medic		1. Decedent's Name (F Ronald		Michael		Sne	11ing			July July	Pa	1, 200	
	Examin	er	4a. Facility Name (If no Doctor's C			L		Lanha	am	r Location of Death	•		County of Dea	
	Funeral Director		5. Social Security Numb 217-70-526		ex 7. Ago Mg 2 □ F	e (In yrs. last bi 49	rthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D March	ay, Year)		thplace (State or Foreign ountry) shington.DC
	and and		Usual Residence of De 10a. State 10	cedent b. County		10c. City, Tov	vn or Loc	cation			- 2 W			10d. Inside City Limits
:	e-f sho	ctor	Maryland P	rince G	eorges	Bowie								1 X Yes 2 □ No
; ;	th with the 23a or 28 ist be no	Funeral Directo	10e. Street and Numbe 14918 Nash					10f. Zip C	ode 207	16		10g. Cit	U.S.A	•
950	permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importment: If litem 27 le marked other then "netural", or Items 23a or 28e-1 show any injury or other treumetic event, It e Madical Examinar must be notified at once.	by	11. Marital Status 1 Never Married 3 Widowed 4	21	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Vas Deceder Yes, specifi Yes 25		ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whi Specify: W	te, etc.
200-0	72 hou	sted		. Decedent's Ed		16a	. Deced	ent's Usual	Occup	ation during most of work	cina .		ind of Business	/Industry
7	within ane. then "	Completed	Elementary/Seconda		College (1-4or 5	+)	life. D	pente:	retired	di)	ang.	Home	e Emproven	ment
7 ·	Hygid Other ent,	Be Co	17. Father's Name (Firs					<u> </u>		18. Mother's Nam	e (First, Middle			
Na i	should be ind Mental marked o umetic eve	To B	Ronald	Lee	Snel	llings				Hortens	se Lo	orrai	ine '	[atro
= -	d 2 sho th and 7 le mu treume		19a. Informant's Name Christine		**					a <i>nd Number or Rui</i> Lane, Bov				1
υ.	is 1 and if Health item 27 other tr		20a. Method of Disposi	tion		20b. Place	of Dispos		of		Date Mai		ocation - City or Ldsonvi	
2 4	Pages nent of I snt: If its ury or o		1 🖾 Burial 2 □ C `4 □ Donation 5 □		Removal from State ')	Lakem					2004	Davi		aryland
	permit. Departinimporte any injir		21. Signature of Funer	al Service Licen	Ser		22.	Name and	Addres	ss of Facility Rob			ns Fune	ral Home
	40380		23a. Part1. Enter the d	disease or com	plications that caused	the death. Do				polis Roa			Marylano	1 20715 Approximate
	Physician /Medical		shock, or heart fa Immediate Cause (Findisease or condition resulting in death)	illure. List only	a. DIA	BET a consequence	()			TOAC			٤	Interval Between Onset and Death
	Interiaw requires that the death bennicate be executed at the bean signed by the attending physician and page 2 should be detached for use as the buriat-transit of	edicai Examiner	Sequentially list conditif any, leading to imme cause. Enter Underlyin Cause (Disease or injuthat initiated events resulting in death) Last	ng ry	b. Due to (or as a	/	of):	N7		ARI	271	MM	A	
.O. DOX	intes that the death certificate is signed by the attending physical be detached for use as the to	hysician/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 moi 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic preg Other <i>(spec</i>					23d. Date of del Month	livery Day Year
olds, r	w requires mat been signed b should be deta	by P	Part II. Other significar	nt conditions co	ontributing to death bu	ut not resulting i	in the un	derlying cau	ise give	en in Part I.		tobacco u Yes 2		o the cause of death?
ו הפכים	dring Priysicien: The law radu h. After this certificate has been funeral director, page 2 should	Completed									24a. Was auto perfo 1 Yes		24b. Were au prior to death?	utopsy findings available completion of cause of 2 \square No
VII	certifi	o Be	25. Was case referred examiner?	to medical	Hospital:				Othe	26. Place of Deat			_	
5	g Friy er this eral di	-	1 Yes 2 No 27. Manner of Death		28a. Date of Injur		Time of		lnjury Worl	4 Nursing Ho	me 5∐Resi 28d. Describe			cify)
	auth. or: Aft	atio	2 Accident	Pending investigation		rear)	Injury	М		Yes 2 □ No				
	after death	Certification:	3 Suicide 6 4 Homicide	G Could not be determined	28e. Place of Inju- building, etc	ry - At home, fa c. (Specify)	arm, stre	et, factory, c	office		28f. Location (City or To	Street an wn, State	d Number or Ru)	ural Route Number,
	to the nospirel or Attending Frigstoell: within Earhours after death. To the Forburs after or After this certifics completely filled in by the funeral director, i	edicai C	29a. Certifier 12 (Check only one)	Certifying Ph Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination ar	e, death nd/or inv	occurred at estigation, in	the tim	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
•	withii To t	×	29b. Signature and title				MI	T) 5	8/ 8 Z		Ju	e signed (Month	2004
			30. Name and address	of person who depends on the constant of the c	H.D. 730.	eath (Item 23a)	(Type, F	Print)	PKK	WAY GR	EEN BEL	T. 4	18 207	770
	Sta Registr		31 Date tiled (Month, L	Jav Yeari	2004 32. Resistra	ir's Signature								

			1 - For State Registrar	State of N	1aryland / [Department Certificate				jiene	11.	22020
			Decedent's Name (First, Middle, La	st)					2. Date of Dea	th	1 4	3. Time of Death
	Physici		Russell Wal	ter	Smith				Month	Day C	Year 2004	0857 M
	/Medio Examir		4a. Facility Name (If not institution, giv				Town, or Location	n of Death		4c. County	of Death	
			PENINGULA REGIA	var ma			5AUSBU				100	
	Funeral		5. Social Security Number 6. S	8ex 7. A X M 2 □ F	ige (In yrs. last bii	rthday) If Under Yrs. Months	1 Year If Under Days Hours	er 24 Hrs. Min.	B. Date of Birth (Month, Day October	Year)	9. Birthp Coun	lace (State or Foreign try)
	Director		217-14-8876 Usual Residence of Decedent		85	115.			October .	3, 1918	Mary	land
	land ow		10a. State 10b. County		10c. City, Tow	n or Location			-		1	0d. Inside City Limits
	Mary	ţ	Maryland Wicomic	0	Salis	hurv						1 ☐ Yes 2 X No
	r 28s	Director	10e. Street and Number		DUITE	10f. Zip	Code		1	0g. Citizen of \	What Coun	try?
	h with	O IE	350 Tilghman Road			21	804			USA		
	be filed within 72 hours after death with the Maryland hat hygiene. Id tygiene. Id other then "naturel" or items 23a or 28s-1 ehow event, the Modical Exaction must be notified at	Funeral	11. Marital Status	12. Was Deceder Armed Forces		13. Was Deced	ent of Hispanic C rfy Cuban, Mexic	Origin? (Spec	ify Yes or No-		e - Americ	
9	or Ite	F	1 Never Married 2 Married	1X Yes 2		1 Yes 2			ican, etc.	Specify	ck, White,	etc.
21215-0036	nours	d by	3 Widowed 4 □ Divorced	Year or Dates	IIWW			···		Specin	Wh	ite
5	"natı	Completed	15. Decedent's E (Specify only highest gra		16a	. Decedent's Usual (Give kind of won life. DO NOT use	k doné durina ma	ost of working	g	16b. Kind of B	usiness/Ind	lustry
12	withir ane. then	D D	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Farmer	ө гепгеа)			Acreio	.1+	
d 2	filed Hygie ther		17. Father's Name (First, Middle, Last	-		ratmet	18. Mot	her's Name	(First, Middle, I	Agricu		2
Maryland	S should be filed withir and Mental Hygiene. Is marked other then eumatic event, Ite M.	Be c	_		la .				, many madaloy m			
<u>Z</u>	d 2 should ih and Men 7 Is marke treumatic	L 0	Lester Earl 19a. Informant's Name/Relationship (Smit Type, Print)		. Mailing Address		enss ber or Bural	Route Number		Rash State Zio	Code)
E	교육자부		. ,	,, ,		ADAMAS NES				Versio Si	5 550	5949.0
ē,	He He		Russell Walter Sm 20a. Method of Disposition		20b. Place o	f Disposition (Nam	e of	Da		20c. Location -		21114-2148 wn, State
9	eg 5 = 9		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from Stat	θ	ry, crematory or ot		14	2004	Colia		Mareland
Baltimore,	그 등 본 글		21. Signature of Funeral Service Lice		MTCOUL		Address of Fac		, 2004	Salisi	oury,	Maryland
ä	Depermine Deperm		> Keeth P &	frema.	FTP	Hollow	ay Funer ow Hill	cal Ho	me Prof	essiona	al As	sociation
	- 11		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the death. Do	not enter the mode	of dying, such a	as cardiac or	respiratory arr	est,	туулаг	nd 21804 Approximate Interval Between
	Physician		Immediate Cause (Final	A p	150 6	UNDOM	deal	Tul	ester!			Onset and Death
П	/Medical		disease or condition resulting in death)	Due to (or a	s a consequence			7	a constant			3 ins.
	Examiner		Conventially list conditions	P	Veubre	D41B						3 days
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	of):						- 1
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
30,	oe ex	û	resulting in death, Last	Due to (or a	s a consequence	of):						
8760,	The law requires that the death certificate be executed at the best been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	•	d								
9	eath certific attending p I for use as	/Me	IF FEMALE;	23c. If yes, outcom	a of prognancy							
Вох	attene for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 ∏ Fetal death at time of death	3 □Ectopic pre 5 □ Other (spe				23d. Dai Mo	te of delive nth	ry Day Year
O.	t the de by the a tached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	at time of death	5 🗆 Other (spe	(City)					
α.	res that tigned by		Part If. Other significant conditions	ontributing to death	but not resulting in	n the underlying ca	use given in Par	t f.	23e. Did tot	pacco use cont.	ribute to th	e cause of death?
Vital Records,	uires sign	d by	Dialutes	UNLLE	rfeed	T Efect.	IT		1 🗆 Ye	s 2 🗆 No	3 Proba	ably 4 □Unknown
00	w require been si should i	Completed							24a. Was a	n 24b. \	Were autoc	osy findings available
Re	The lav	mo							autops perform 1 Yes 2	v r	prior to con death?	npletion of cause of
ta		Ö	25. Was case referred to medical				26 Pla	ce of Dooth	1 Yes 2 Check only on		Yes	2 L No
	Physicien: this certific ral director,	0 8	examiner? 1 □ Yes 2 ▼No	Hospital:	tient 2 ER/Ou	utpatient 3 DO	Other			ence 6 Oth	er (Snacify	à
of	g Ph er thi	n:T	27. Manger of Death	28a. Date of fn (Month, D		Time of 28	Bc. Injury at Work?			w injury occurr	(-1 .).	
ior	Attending r death. sctor: After by the funer	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio		ay 10a1)	njury M	1 ☐ Yes 2 [□No				
Division	r Atte er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	200. Place of I	njury - At home, fa	rm, street, factory,	office	28	If. Location (St. City or Town	reet and Numb	er or Rural	Route Number,
ā	tel or rs aft el Di	Cer						10				
	Hospitel or 24 hours afte Funerel Dir tely filled in I	cal	(Check only 2 Medical Exam	nysician: To the bes miner: On the basis	t of my knowledge of examination an	e, death occurred and/or investigation.	it the time, date a	and place, an	d due to the ca	ause(s) and ma	nner as sta	ated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	one)	and manner	stated.							
	To To	4	29b. Signature and title of certifier	Helen Bal	dado,MD		License number		25	9d. Date signed	(Month, L	Jay, Year)
7			Suu or	1. 1000	acac		D1684			1/7/	02	7
DG	2		30. Name and address of person who	completed cause of	death (Item 23a)		lips	2 de	100	2187		
	Sta	te	31. Date filed (Month, Day, Year) JUL 13 2	32. Regis	trar's Signature	4 Lon	all					
	Registr		JUL 132	UU4		. دومر						

Please Type or Print in Black In	ndelible lnk. Ensure Al	l Copies Are	Leaible.	
State of Maryland / Department	artment of Health and M	-	_	
FOI	ertificate of Death	Reg. Ni		20000
Decedent's Name (First, Middle, Last)		2. Date of Death	2004 K	3. Time of Death
MADELINE JUANITA SPE	ENCE	July of	4 2 004	10 35 M
4e. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	
Manokin Manor	PrincessA	NNE.	Somer	7637
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Year	9 Birthplac	ace (State or Foreign
213-24-1372 10M 28 80 Yrs.	Months Days Flours	5-26-	24	mD.
Usual Residence of Decedent			10	* Incide Oils Limite
10a. State 10b. County 10c. City, Town or Lo	cation		100	d. Inside City Limits 1 ☐ Yes 2 No
MD DOMERSET VEN	1100	1:0:0		
10e. Street and Number	10f. Zip Code	10g. G	Citizen of What Country	y?
28098-BLACK DD.	21853		USH	
	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Black, White, etc	
1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: BU	ACK
15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of workin	16b. F	Kind of Business/Indus	stry
Elementary/Secondary (0-12) College (1-40r 5+) ==	e kind of work done during most of working DO NOT use retired)	'9	D-ONU	-
	SCERATION	1111	JEVAN	5
17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maider	6.1	
ELIJAH D. HOLBROOK	EVA G	LUCKER		ROOK
	ling Address (Street and Number or Rura)	1	or Town, State, Zip C	ode)
	98 - BLACK KD,	VENTON	J. MID, =	21853
20a. Method of Disposition 1⊠ Bultial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cre-	position (Name of permatory or other place)	Date 20c. L	Location - City or Town	n, Stete
*4 Donation 5 Other (Specify) ORACE	CAMETARY 7/11	0/04	ENTON	MD
21. Signature of Funeral Service License e	22. Name and Address of Facility	ENNIE	SMITH	FIH
first food	117-W. ISABELLI	A ST. SAL	USBURY,	MD, 21801
23a. Pert1. Enter the disease, or complications that caused the deeth. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cerdiac or	r respiratory arrest,] In	Approximate nterval Between
Immediate Cause (Final disease or condition	lacemer Ve	mentea	6	Onset and Death
resulting in death) Due to (or as a consequence of):	1			-1/
Sequentially list conditions.				
Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury				
that initiated events C.				
resulting in death) Last Due to (or as a consequence of):				
d				4.42
1 Ves 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Da	/ Pay Year
9 Unknown				
Part II. Other significent conditions contributing to death but net resulting in the u	inderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
Viabetes (Mellitus/9	fe #	1 ☐ Yes 2	2 🛣 No3 🗆 Probab	oly 4 Unknown
Prientio Hupertenser		24a. Was an	24b. Were autops	sy findings available
Potes in the de Diversule	Diseese	autopsy performed? 1 ☐ Yes 2 ☑ No	death?	oletion of cause of
moderna a carrie a con a	7	10100	/	

Physician /Medical **Examiner**

Examiner Completed by Physician/Medical

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: Alter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be

25. Was case examiner? 2€ No 1 Tes 27. Manner of Death

29a. Certifier

1 - For State Registra 1. Decedent's

Physician

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depentment of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

To Be Completed by Funeral Director

/Medical Examiner

> 1 X Natural 2 ☐ Accident 3 Suicide 4 🗌 Homicide

5 ☐ Pending investigetion 6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number D 29505 29d. Date signed (Month, Day, Year)

86. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 GREGORIO

State Registrar

31. Date filed (Month Day, Year) 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** MARIE M. SEIDL JULY 7 2004 12:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO NURSING HOME SALISBURY If Under 1 Year WICOMICO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-29-1914 Birthplece (State or Foreign Country)
 PENNSYLVANIA 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 ☐ M 2 🖸 F 056-07-5274 89 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director DELMAR WICOMICO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21875 33267 MELSON ROAD Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2V No 1 Never Married 2 Married If Yes, Give AY Year or Dates: 1 ☐ Yes 2 No Specify Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) CIVILIAN Elementary/Secondary (0-12) College (1-4or 5+) LEGISLATIVE LAW SPECIALIST LAW LIBRARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KATHARINA WALTERS JOHN NOSTADT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 33269 MELSON ROAD, DELMAR, MARYLAND 21875 ANTHONY SEIDL - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 07-12-2004 CLINTON, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Juneral Service Licensee 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Bart 1. Enter the disease Immediate Cause (Final disease or condition resulting in death) EREBROVASCUL **Physician** WITH (R) HEMIPARESIS /Medical Due to (or as a consequence of) **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ARTHRIA this certificate has autopsy performed 2)X No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Hospital: ပို 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Medenter

Registrar

DHMH 17 Rev 1/2001

State

Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

614 EASTERNSHORE DRIVE SALISBURY MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MAHESHA THIMMARAYAPPA M.D.

JUL 0 9 2004

31. Date filed (Month, Day, Year)

Director

Completed by Funeral

Be ဥ

Physician

/Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28e-f show any hjury or other traumatic event, the Madical Eraminer must be nutified at once.

Physician /Medical

For		State of M	aryland / De	•		ina me	intai mygie	∍ne	
State Registrar			C	Sertifica	ate of Death			3. No. 1	4 23832
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216-18-90 sual Residence of D	054	1X M 2□F	80 Yrs	Month		Min.	Month, Day, Y	(ear)	9. Birthplace (State or Foreig Country) IARYLAND
a. State	10b. County		10c. City, Town o	or Location					10d. Inside City Limit
MD	TALBO	Γ	ST.	MICHAI	ELS				1 ☐ Yes 2 🔀 No
e. Street and Numb	ber			10f.	Zip Code		100	g. Citizen of Wha	at Country?
8526 BOZI	MAN-NEA	VITT RD.			21663			US	SA
1. Marital Status 1 □ Never Married	_	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give	Ever in U.S.		cedent of Hispanic Origination of Hispanic Origination (Capacity Cuban, Mexican, Specify:	in? (Speci , Puerto Ri	fy Yes or No- can, etc.)		American Indian, White, etc. WHITE
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Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 page 2 within 24 hours after death. To the Funerel Director: After this certific completely fiiled in by the funeral director.

Examine Be

Physician/Medical

Completed by

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Certification;

Medical

State Registrar

29b. Signature and title of certifier

29c. License number 737887 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29466 PINTAIL DRIVE EASTON, MD 21601 DAVID SMITH M.D.

31. Date filed (Month, Day Year)

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	or 28	Director	10e. Street and Number			10f. Zip Co		1	0g. Citizen of What	Country?
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Φ.	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	by Pt	Part II. Dther significent conditions con	ntributing to death but no	t resulting in the u	inderlying caus	se given in Part I.	23e. Did tot		e to the cause of death?
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State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death 3. Time of Death D 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** aver /Medical ounty of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HM Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Min. 1**X**]M 2□F Months Hours 47 Director April 26, 1957 214-68-6926 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Directo Maryland | Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21804 USA "natural", or itams 23a 310 Buena Vista Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after IX Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Flementary/Secondary (0-12) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Item 27 is marked other th any injury or other treasment. Social Worker Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Travers Unknown Annie Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Virginia Travers (mother) 310 Buena Vista Avenue, Salisbury, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State July 15,2004 Libertytown, Maryland ⁴ □ Donation 5 □ Other (Specify) Riverside Cemetery 21. Signatur Funeral Service Licey ee 22. Name and Address of Facility Holloway Funeral hOme Professional Association Dn. 501 Snow Hill Road, Salisbury, Maryland 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final **Physician** 4 day disease or condition resulting in death) /Medical Due to (or all a consequence of): **Examiner** and Stapylococcal Eactronia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 hknown 200 director, page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an certificate has autopsy perform Was case referred to medical examiner? 1 Yes 2 Vo Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XXNo ٥ 1 / patient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Matural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or hin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen A. Korzick 301 St. Paul Place, Burk Bldg. #314, Baltimore, Maryland 31. Date filed (Month, Day, Year)

JUL 1 3 2004 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene

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			1. Decedent's Name (First, Middle, La	ist)						2. Date of Dee	th	114	3Time of Death O
	Physicia		Stephen		T_{Σ}	ma .				Month July 1	Day 20	Year 04	2:05 PM
	/Medica Examine	_	4a Facility Name (If not institution, given	e street and numbe				4b	. City, Town, or Lo		4c. Count		2.05 111
			Holy Cross Nursi	ng Center	•			B	urtonsvi:	11e	Montg	omery	7
	Funeral				Age (In yrs. lasi		If Under 1 \	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day			place (Stete or Foreign
	Director		092-12-5344	MX 2□F	81	Yrs.							sylvania
	pu s	-	Usuel Residence of Decedent 10a. State 10b. County		10c City T	own or Loc	eation						10d. Inside City Limits
	show	5	Maryland Montgome	rv		tonsv							1 TX Yes 2 □ No
	r 28a-f sh	S	10e. Street and Number	- 3	Dur		10f. Zip Co	ndo			l0g. Citizen of	What Cou	21
	A PO	by Funeral Director	3415 Greencastle	Road			2086				U.S		miy r
	eath w	era	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13 W			panic Origin? (Sp	ecify Yes or No-			can Indian,
	ter d		1 Never Married 2 Married	Armed Forces	5?	If	Yes, specify	Cuban	panic Origin? (Spo , Mexican, Puerto	Rican, etc.)		ck, White,	
020	urs ef	à	3 ☑ Widowed 4 □ Divorced	1X Yes 2 If Yes, Give Year or Dates	1942-46	5 1	□Yes 21人] No	Specify:		Specif	y: Whi	.te
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218	hin 7	<u> </u>	(Specify only highest green Elementary/Secondary (0-12)	College (1-40	r 5+)	life. D	O NOT use i	retired)	iring most of work	ing	U.S. F		
21	filed wil Hygien ther the	Ö		3		Compu	iter S	pec:	ialist		Gov	ernme	nt
pu	al Hygie I other went,	Be Completed	17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle,	Maiden Sumar	ne)	
<u>ya</u>	should be nd Mental marked o	<u> </u>	Stefan	Tyma					Anna	Wa	shick		
Maryland	2 shc end is m		19a. Informant's Name/Relationship						nd Number or Rure				Code)
	ealth		C. Annette Galind	o/ Daught			-	2.60	Way, Gaml				1054
Baltimore,	iges 1 and 2 should be filed within to f Health and Mental Hygiene. If Item 27 is marked other than or other traumatic event, the Mental files.	- 1	20a. Method of Disposition 1 □⁄⁄2Burial 2 □ Cremation 3 □	Removal from Stat	e Morra	e of Dispos etery, crem	atory or othe	of ir place)		20c. Location	•	, -
Ë	permit. Peges 'Department of H important: If ite any Injury or of	1	4 Donation 5 □ Other (Special	(y)	rial	y Land	Veter Cemete	ry	1/1				Maryland
3all	Departimborrimporr	1	21 Signature of Funeral Service Line	nsae		22	Name and A	Address	of Facility Rol	bert E.			
	₫ O = @ d		1 the	-5		160	000 An	nap	olis Road	d, Bowie	, Mary	1and	20715
9	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		line.	anc	ula		Out	. 1	est,		Approximate Interval Between Onset and Death
•	el-trensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (or as	s a consequ	rence of):						
x 68760,	tificete be ig physicie es the bur	edicai	Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (or as	a consequ	ence of):						
Box	etten for us	Dy Physicianym											
P.O.	the de	2	Part II. Other significant conditions of	ontributing to death	but not resultin	g in the un	derlying caus	se giver	in Part I.				the cause of death?
	that that the determinant							_		1 U Y	es 2 No	3 ☐ Pro	bably 4 Unknown
Records,	been s	Completed D						-		24a. Was a perfore		av	ere autopsy findings ailable prior to mpletion of cause death?
č	The li									1UY	0 2 NNC	1[]Yes 2□No
ita	an:		25. Was case referred to medical						26. Place of Death	(Check only or	ne)	1	
f V	ysici is cel direc	2	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 ER	/Outpatient	3□ DOA	Other	Nursing Hor	me 5 Reside	ence 6 🗆 Oth	er (Specif	y)
Division of Vital	ig Ph ter th nerel		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of In (Month, D	jury 28 Pay Year)	b. Time of Injury	28c.	Injury a	at :	28d. Describe h	ow injury occur	red	
Sio	endir eath. or: Af	2	2 ☐ Accident investigatio	n			М		es 2□No				
Ž	r Att		3 ☐ Suicide 6 ☐ Could not be determined	286 Place of I	njury - At home etc. (Specify)	, farm, stre	et, factory, of	ffice		28f. Location (Si City or Town		er or Rura	I Route Number,
Ω	Ital of Ital of Ital of Ital of Ital	3											
	To the Hospital or Attending Physician: The lew within 24 hours efter death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edicai cer illication.	29a. Certifier (Check only one) Certifying Pt 2	ysician: To the bes	of examination	dge, death and/or inve	occurred at to estigation, in	ne time my opii	, date and place, a nion, death occurre	and due to the co ed at the time, d	euse(s) and ma ate and place,	anner es s and due to	tated. the cause(s)
	ithin i		29b. Signature and title of certifier	end manner	oldiou.		29c. Li	icense	number	2	9d. Date signe	d (Month.	Day, Year)
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		-	30. Name and address of person who	completed course of	death (Item 22	le) (Tuno D			v / -1 0		-		E
			Marcia Goldmark,					Su	ite G, N.	Potoma	c, Mary	yland	21078
	State		31. Date filed (Month, Day, Year)		trar's Signature		<i>y</i>				-		
	Registra		JUL 14	2004	rue l	* A							

DHMH 16 Rev 6/95

			For State Registrar	i icus	State	of Ma	ryland / Do	epartmei Certifica				nental Hy	giene		23837
			1. Decedent's Name (First, Middle, L	.ast)							2. Date of De Month	aath Day	Year	3. Time of Death
	Physicia /Medic		MARY ELIZA	ABETH U	JLLRICH							JULY	7		04 10:00 MM
	Examin		4a. Facility Name (If no	ot institution, g	ive street and nu	umber)		4b. City		Location (of Death		4c.	County of Dee	oth
		100	BERLIN NUI					1/11		RLIN	0411			WORCE	
	Funeral		5. Social Security Num		Sex 1 ☐ M 2 X ☐ F		(In yrs. last birth	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Di 07-23-	rth ay Year)	V.TE C	thplece (State or Foreign ountry) T VIRGINIA
	Director		215-10-860				94 Y	<u> </u>	1			07-23	1907	WES	VIRGINIA
	land ow			0b. County			10c. City, Town	or Location							10d. Inside City Limits
	Mary I sh	ţ	MD	WORCES	STER		BERLIN								1 ☐ Yes Zy ☐ No
	r 28e	Director	10e. Street and Numb	er				10f. Z	ip Code				10g. Citi	zen of What C	ountry?
	h wit		25 WILLOW	WAY						218	311			USA	
	deal	Funeral	11. Marital Status		12. Was Dec	cedent Ev	ver in U.S.	13. Was Dece	edent of H	ispanic Or In, Mexical	igin? (Sp	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whi	
92	or It		1 Never Married		1 □Yes If Yes, G	ive No				Specify:				Specify: TuT	HITE
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examinar marke notillied at	d by	3 XWidowed 4		Year or	Dates:		ecedent's Us	ial Occup	ation			16h Ki	nd of Business	
_	n 72	lete	(Specify		grade completed			Give kind of wife. DO NOT	ork done i use retired	during mos	st of worl	king	100.10		an daday
MARY 1d 2121	withi iene. than than	Completed	Elementary/Second	ary (0-12)	College	(1-4or 5+	-)	CLE	RK				FIDI	ELITY &	DEPOSIT
MA	should be filed within 72 hours after death with the Marylan of Mental Hygiene. rnarked other than "natural", or flems 23a or 28a-1 show imatic event, the Medical Examiner must be notified.	Be C	17. Father's Name (Fin	rst, Middle, La	st)							e (First, Middle			
<u>a</u> -	Mental Mental rked o	To B	JAMES J.	MCKAY						MARY	Y FR.	ANCIS M	ORGAI	V	
ULLRICH, M.	d 2 should be filed th and Mental Hygi 7 is marked other traumatic event,		19a. Informant's Nam	e/Relationship	(Type, Print)				,			ral Route Numb			
	is 1 and 2 of Health item 27 other tra		CHARLES M		ICH,JR -	- SON	-			AVENU		BERLIN,			
	9 - = 0		20a. Method of Dispos 1 Burial 2 □		☐Removal from	n State		crematory or	other place			Date		cation - City or	
D Ë	Pa ant ury		° 4 ☐Donation 5	Other (Spe	cify)	1-	ST. MAR			-		0-2004		-	IRGINIA
ULLE Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Fuere	Mich C	ensee	lu	N					UNDS FU ET,SALI			LAND 21804
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760,	be exi	cal E	Todaking in South, Sak			o (or as a	consequence of).				•			
687	phys phys s the				d										
Вох	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 1 9 ☐ Unknown	onths?		birth 2 gnant at t	of pregnancy 2 Petal death ime of death	3 Ectopic 5 Other (s		·				23d. Date of de Month	elivery Day Year
P.0	that the de led by the a detached t		Part II. Other significa	ant conditions	s contributing to	death but	t not resulting in	he underlying	cause giv	en in Part	1.	23e. Did	tobacco u	ise contribute t	to the cause of death?
ds,	uires tha signed Id be de	d by	Esser	rtia	e 24	ys.	erten	sien	-			1 🗆	Yes 2	No 3□P	robably 4 Unknown
202	w require been sign	Completed	(0)		(the same	Deser	72	\	3 40		24a. Was		24b. Were a	utopsy findings available
Re	The law ate has page 2	m d		pur.	-		7						ormed?	prior to death?	completion of cause of
ta	ician: Th certificate rector, pag	a)	25. Was case referred	d to medical			1.7			26. Place	e of Dea	th (Check only	2 № No one)	1018	2 2 140
5	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 🗷 No		Hospital:	Inpatien	nt 2 ER/Outp	atient 3 🗆 🗈	Oth	00		ome 5 Res	-	6 □Other (Spe	ecify)
Division of Vital Records,	ttending Phydeath.		27. Manner of Death 1 Natural 2 Accident	5 Pending	(Mo	e of Injury onth, Day	Year) 28b. Ti	me of ury . M	28c. Injur Wor 1 🗆	yat k? Yes 2 □]No	28d. Describe	how injur	y occurred	
Divis	al or Attences after death	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	20e. Plac	ce of Injui Iding, etc.	ry - At home, farr (Specify)	n, street, facto	ery, office				(Street an wn, State		tural Route Number,
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	To the within To the comp	Me	29b. Signature and tit	le of certifier	7	> .	0	20 2	9c. Licens				29d. Dat	te signed (Mon	th, Day, Year)
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tod	2		31. Date filed (Month	Day, Year)	SE LLOS	Begistra	r's Signature	1 CH	NAE	CKK	YV	K, DA	F12R	LLKY,	MD 21801
1 "	Sta Registi		31. Date filed (Month	L 082	2004	Jene	r's Signature	g Sp	als						

		1. Decedent's Name (First, Middle, Las	20b PER FH	6033 00	. unoal	e of Dea		2. Date of Dea		UU	3. Time of Death
nysicia Medic	เท	CAMERON WILLIAMS						JUNE	29,	2004	6:00P
xamin		4a. Fecility Name (If not institution, give	street and number)		4b. City,	Town, or Loca	tion of Death		4c. County	of Death	
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neral ector		215 47 8359	X / Age (/	n yrs. last birthday,	Months		urs Min.	8. Date of Birtl (Month, Da) APR. 03	r, Year)	9. Birting Cour MAF	lace (State or Fore stry) XYLAND
lied at		Usuel Residence of Decedent 10a. State 10b. County MARYLAND PRINCE G		Oc. City, Town or L	ocation					1	0d. Inside City Lim
inorii	Director	10e. Street and Number			10f. Zij	Code			10g. Citizen of V	What Cour	ntry?
4		4514 WOODGATE WAY				207			UNITE		
imporant: It tens 47 is marked other train instituting, or teins 428 or 428-1 show in injury or other treumatic event, the Medical Examinar must be notified at once.	by Fur	11. Marital Status XX Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:	ar in U.S. 13.	Was Dece If Yes, spe 1 Yes	cify Cuban, Me	ic Origin? (Sp exican, Puerto ecity:	ecify Yes or No- Rican, etc.)	Blac	e - Americ ck, White, : BLA	
Medical	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)		(Give	dent's Usu kind of wo DO NOT u	al Occupation ork done during ise retired)	most of work	ing	16b. Kind of Bu	usiness/In	dustry
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eumatic event, the M	To Be	17. Father's Name (First, Middle, Last)	unk					e (First, Middle, WILLIAM		10)	
treuma		19a. Informant's Name/Relationship (7 MONICA WILLIAMS /	Гуре, Print) MOTHER		•	s (Street and N GATE WA		al Route Numbe		State, Zip	Code)
or other	1	20a. Method of Disposition 1XXX urial 2 Cremation 3 C	Removal from State	20b. Place of Disp cemetery, cre	matory or	other place)		07,200			
eny injury		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen			2. Name a ARSHA		Facility INERAL	HOME OF	CLINT MARYLAI LAND, MI	ND,IN	iC.
ician dical niner		23a. Pert1. Enter the disease, or companies, or heart failure. List only a limmediate Cause (Final disease or condition resulting in death)	one cause on each line.	NT BRAIN			ch as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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led by the attending pridetached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at tin	Fetal death 3	□Ectopic p					te of delive	ary Day Year
should be deta	by	Part II. Other significant conditions of	ontributing to death but i	not resulting in the	underlying	cause given in	Part I.	23e. Did to		ribute to ti 3 □ Prob	ne cause of death? ably 4 □Unkno
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the i	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	9	r - At home, farm, s (Specify)		1 ☐ Yes	2 0.140	28f. Location (5 City or Tow		er or Rura	il Route Number,
od in b	U .	29a. Certifier XX Certifying Ph	ysician: To the best of niner: On the basis of earth manner state	xamination and/or i	th occurred nvestigatio	d at the time, da n, in my opinior	ate and place, n, death occur	and due to the ored at the time,	cause(s) and ma date and place,	anner as s and due to	tated. the cause(s)
e Funerel Dire	dical	(Check only 2 Medical Examone)	and mainter state								
To the Funerel Director: After th completely filled in by the funeral	Medical			D	29	c. License nun			29d. Date signe		
To the Funerel Directory Completely filled in by	Medical	one)	M			D00539			JULY 0		

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F		1. Decedent's Name (First, Middle,	Last)						2. Date of Month	Death	Day	Year	3. Time of	Death
ysicia Aedic		Raymond	C.			Whipple	e		July	12		2004	5:30	P 1
amine		4a. Facility Name (If not institution,	give street and number	r)		4b. City, Town, o	or Location	of Death			4c. Co	unty of Deat	th	
		12505 Swirl Lane				Bowie					Pr		Georges	
eral ctor		5. Social Security Number 072-22-4183 Usual Residence of Decedent	6. Sex 1X—XM 2□ F	76	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of (Month, June	Day, Y			thplace (State of buntry) York	r Forei
77		10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside Ci	ty Limi
any injury or other traumatic event, the Madical Examinat must be rediffied at once.	tor	Maryland Prince	Georges	Bowie	9								1 🔀 Yes	2 🗆 1
Total I	Funeral Director	10e. Street and Number				10f. Zîp Code				10g	. Citizen	of What Co	ountry?	
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2	ner	11. Marital Status	12. Was Deceder Armed Forces		. 13.	Was Decedent of H	lispanic Or	rigin? (Spe	ecify Yes or	No-		Race - Ame Black, White	erican Indian,	
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Registrar

JUL 1 4 2004 Segistrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dav **Physician** Arthur Edward WALLECH Ju₁y 15, 2004 11:45 p.m /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Julia Manor Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1⊠M 2□ F 58 Yrs Director 220-42-5951 July 2, 1946 Maryland Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours effer deeth with the Maryland Department of Health end Mental Hygiene. Important: If flem 27 is marked other than "natural" ~ " any injury or other traumatic excent any injury or other traumatic excent any injury or other traumatic excent any injury or other traumatic excent any injury or other traumatic excent any injury or other traumatic excent and injury or other excent and injury or o 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director Maryland Washington Clear Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12535 Rockdale Road 21722 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: white Completed by 3 Widowed 4 Divorced Year or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 painter contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Wallech, Sr. Anna C. Poper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard King - son 156 S. Potomac St., Apt. 2N, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/16/04 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Md. 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Wedical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Cardiomyor Hospital or Attending Physician: The law requires that the deeth certificate be executed use as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Diseasi Physician/Medical Due to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown δ 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificete 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this I Director: After this ad in by the funerel d 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of Injury edical Certification: 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter 4 Homicide To the Hospital within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 00060396 07116104 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) MURSHED FARID Court Hag, md 21740 Opal

DHMH 16 Rev 6/95

State Registrar 32. Figistrar's Signature

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	Europet		5. Social Security Numbe			Age (In yrs. Ia	st birthdav)	If Under		If Under a	24 Hrs.	8 Date of Bi					or Foreign
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show appringing or other traumatic event. The Medical Eventing rotal be natified at ODGE.	Funeral Director	10e. Street and Number 1635 Edgewo					10f. Zip	Code 740				10g. Citi:	zen of Wh	at Coun	try?	
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Maryland 21215-0036	2 sho and h Is ma	ľ	19a. informant's Name/R				19b. Mailir	g Address	(Street a	nd Numbe	r or Rura	l Route Numb	er, City or	Town, St	tate, Zip	Code)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12, 6:35 am July 2004 ELIZABETH C. WRIGHT /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Easton Maryland
If Under 24 Hrs. 8. Date Talbot Genesis Eldercare 8. Date of Birth (Month, Day, SEPT 17 Birthplece (Stete or Foreign Country)
 PA 7 Age (In vrs. last birthday 5. Social Security Number **Funeral** Months Days Min 1 M 2 XF Hours 214-42-8021 88 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at any injury or other traumatic event, the Medical Exeminer must be notified at any injury or other traumatic event. 10a. State 10b. County 1X Yes 2 No Be Completed by Funeral Director EASTON TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 **IISA** 610 DUTCHMANS LANE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify: WHITE Specify 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ TEACHER ELEMENTARY EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LAURA GLEN LOUIS F. COFFIN ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LOUIS C. WRIGHT/SON 9160 FOX MEADOW LANE, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 7-13-2004 STEVENSVILLE, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERON JOHN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final moutheimen **Physician** 12 maks disease or condition resulting in death) /Medical for as a consequence of Examiner wars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transil resulting in death) Last Due to (or as a consequence of): ding physician by Physician/Medical the 35 IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate 1 Yes 2 No Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 2 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t edical Certification: the Hospital or Attending Injury Natural 5 Pending after death.

Director: Aff 2 No investigation 1 TYes 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WD 508 MICHALL (ROWLLY

State Registrar Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Elizabeth Wright

ORIGINAL

2. Registrar's Signature

			f _ For State	·	artment of Health and tificate of Death	Mental Hygi	ene	00011
	Physici	an	1. Decedent's Name (First, Middle, Last)		imeate of Death	2. Date of Death Month	Day Year	3. Time of Death
10	/Medic Examir		LEONA SCHMICK WRICE 4a. Fecility Name (If not institution, give street and		4b. City, Town, or Location of Dea	JULY	12 2004 4c. County of Deat	3:15PM M
			WILLIAM HILL MANOR		EASTON			вот
3	Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 M 2 1	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year If Under 24 Hr. Months Days Hours Min	(Month, Day,	Year) 9. Birt 1917 MA	pplece (State or Foreign untry) RYLAND
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation	-		10d. Inside City Limits
	Ba-fs!	Director	MD CAROLINE	PRESTON	7.			1 ☐ Yes 2 🙀 No
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ylar	Mental Mental arked o	To B	JOHN T. SCHMICK		ELSI	E GOEHRIN	GER	
, Maryland	id 2 lith al 27 is		19a. Informant's Name/Relationship (Type, Print) FREDERICK H. SCHMICK/		g Address (Street and Number or R BACK LANDING RD			. ,
altimore,	00		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal f 4 □ Donation 5 □ Other (Specify)	rom State	sition (Name of latory or other place) ILL CEMETERY 7-1	6	Oc. Location - City or TEASTON, MA	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee		Name and Address of Facility LLOWS, HELFENBET OS. HARRISON ST			
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/60,	le be executed ysician and e burial-transit	cal Exa	resulting in death) Last Due	e to (or as a consequence of):				
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VItal		Be C	25. Was case referred to medical		26. Place of De	1 Yes 2 ath (Check only one)	XNo 1 ☐ Yes	2 □ No
-	A .20 D	ို	27. Manner of Death 28a. D 1 ☑Natural 5 ☐ Pending	□ Inpatient 2 □ ER/Outpatient ate of Injury Month, Day Year) 28b. Time of Injury	3 DOA Other: 4 Nursing H		ce 6 □Other (Specinjury occurred	(ty)
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	e Hospite 124 hours E Funerel letely filled	edical C	Check only 2 medical Examiner: On tr	the best of my knowledge, death ne basis of examination and/or invi nanner stated.	occurred at the time, date and place estigation, in my opinion, death occurred.	a, and due to the cau arred at the time, date	se(s) and manner as a and place, and due to	stated. o the cause(s)
	To th within To th compi	Me	29b. Signature and title of certifier		29c. License number	290	. Date signed (Month,	Dey, Year)
			Robert W. Tr	ever, M.D.	Dioq38	8	uly 13, 2	.004
			30. Name and address of person who completed of			01/01		
	Sta	tę	ROBERT W. TREVER M.D. 31. Date filed (Morgon Ay, Year)	Registrar's Signature	m .	21601		
	Registr	-	JOL I 4 2004	me & So	THE STATE OF THE S			

		For State Registrar AMEND TTEM #29d PER PHY (1. Decedent's Name (First, Middle, Last)	333C91Hispig of Peath	2. Date of Death 3. Time of Dea
Physicia /Medic Examin	al	George T. Zell, Ia. Facility Name (If not institution, give street and number)	Jr. 4b. City, Town, or Location of Death	July 10, 2004 11; 00
Funeral Director	-1	Heartland Health Care Center 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. 1 M 2 F) 59	Hyattsville Asst birthday) Yrs. Hyattsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Prince Georges 8. Date of Birth (Month, Day, Year) July 9, 1945 Prince Georges 9. Birthplace (State or For Country) Washington,
e Maryland 8e-f show	ctor	Maryland Prince Georges Hya	y, Town or Location ttsville	10d. Inside City Lir 1 X ☐ Yes 2 ☐
ors a	by Funeral Director	10e. Street and Number 6500 Riggs Road 11. Marital Status 1 ★ Never Married 2 ★ Married 3 ★ Widowed 4 ➡ Divorced 12. Was Decedent Ever in U. Armed Forces? 1 ★ Yes 2 ★ No If Yes, Give Year or Dates: 1965	S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	10g. Citizen of What Country? U.S.A. Decify Yes or No- Pican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
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2 should be filt or and Mental Hy is marked oth reumatic event	To Be	George T. Zell, Sr.	Doroth	-
and tealth m 27 her t		19a. Informant's Name/Relationship (Type, Print) Marie Marshall/ Daughter 20a. Method of Disposition 20b. P	8494 Kirby Street, Man	ral Route Number, City or Town, State, Zip Code) LASSAS, Virginia 20110 Date 20c. Location - City or Town, State
it. Page rtment o rtent: If njury or	-	1XDBurial 2 □ Cremation 3 □ Removal from State Quarter 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	cemeterv	/2004 Quantico, Virginia bert E. Evans Funeral Home
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		building, etc. (Specify 29a. Certifying Physician: To the best of my kno	wledge, death occurred at the time, date and place,	City or Town, State) and due to the cause(s) and manner as stated.
ithin 24 l	Medical	(Check only one) 2 Medical Examiner: On the basis of examinal and manner etated. 29b. Signature and title of certifier.	tion and/or investigation, in my opinion, death occurring the second section and the section and the second section and the section and	29d. Date signed (Month Day Xear)

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	g a g	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wa				gin? (Sp	ecity Yes or No- Rican, etc.)	. 1	4. Race - A	merican Indian,	
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other then "natural", or Iteme 23e or 28e-f ehow important: If item 27 le marked other then "natural", or Iteme 23e or 28e-f ehow any loury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	r in U.S.	13. Was Deced If Yes, spec		anic Origin? (S Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.))-	14. Race - Ameri Black, White,	
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Divis	- 0	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	At home, farm,	, street, factory	, office		28f. Location (5 City or Tox		Number or Rure	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of m ner: On the basis of ex- and manner stated	amination and/o	eath occurred a r investigation,	at the time, in my opini	date and place on, death occu	, and due to the cred at the time.	cause(s) date and	and manner as si place, end due to	ated. the cause(s)
	. /	M	29b. Signature and title of continer	16	>		License no	umber 557/8		29d. Date	signed (Month,	Doy, Year) ZOOY
	12		30. Na and address of person who con Ross Switkes, M.D.	eted cause of death WAH 7600	(Item 23a) (Ty Carroll	_{ре, Print)} . Avenue	e Tako	oma Parl	k, Marvl	and	20912	,
	Sta Registr	-	31. Date filed (Month, Day, Year) JUL 1 4 200	32. Registrar's	Signature 🥻		ekst					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** P^{M} Lex Whitehill Barnett July 8, 2004 2:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Bethesda Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2 □ F 177-07-6101 89 May 29, 1915 Director Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Evander must be redified at 1 Yes 2 □ No Maryland Montgomery Garrett Park Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10806 Montrose Avenue 20896 United States death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ॼYes 2□No World If Yes, Give Year or Dates:War II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Comm. Printing event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be Marvin Barnett Mamie Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Beatrice Barnett / Wife 10806 Montrose Avenue, Garrett Park, MD 20896 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition commetery, grematory or other place)
Parklawn
Memorial Park July 11, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Rockville, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ vicenses Rockville, Rockvi Inc. 300 West lle, Maryland Avenue, M00689 Part1. Exter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shocker healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia 3 years /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any later to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed physician and s the burial-transit Hypertension Due to (or as a consequence of) Box 68760. Completed by Physician/Medical attending for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 21 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed? 1 ☐ Yes 2X No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4x Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 2 ER/Outpatient 3 DOA this Alter thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation within 24 hours after community of To the Funeral Director: All 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

Registrar DHMH 17 Rev 1/2001

State

+

29b. Signature and little of certifier

31. Date filed (Month, Day, Year)

JUL 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

32. Registrar's Signature

appeared,

Alan R. Sheff, M.D. 10215 Fernwood Road, #100A, Bethesda, Maryland 20817-1183

29c. License number

D36797

29d. Date signed (Month, Dey, Year)

July 9, 2004

			1 - For State Registrar	State of M	1arylan		artment o			nd M	ental Hy	gien Reg. N	21111	4	2381	, 9
	Physici	an	Decedent's Name (First, Middle, Last) Helen Scott	R	eaver						2. Date of De Month July	ath		Year 1	3. Time of 12:15	
	/Medic Examin		4a. Facility Name (If not institution, give s Lorien Nursing & F	reet and number	r)		4b. City, Tow			Death	July		c. County o			
	Funeral Director		Social Security Number 6. Sex			last birthday) Yrs.	If Under 1 Ye	ear If	Under 2 lours	4 Hrs. Min.	8. Date of Bi (Month, D April 2	th Yea		9. Birthpl	ace (State of try) ingto	Foreign
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	rv		y, Town or Lo	cation Spring							10	0d. Inside Cit	
	with the f a or 28a- Le notifi	Direc	10e. Street and Number 3589 South Leisure		1		10f. Zip Cod					10g. C	itizen of WI	nat Count	try?	
036	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or Itema 23a or 28a-f show of other than "natural", or Itema 23a on 28a-f show avent, Ite Marical Execution multical at	by Funerai		2. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	nt Ever in U. s?] No	1	Vas Decedent f Yes, specify (1 ☐ Yes 2 🛣	of Hispa Cuban, M	anic Orig Mexican, Specify:	in? (Spe Puerto l	cify Yes or No Rican, etc.))÷	14. Race	White, e	etc.	
Baltimore, Maryland 21215-0036	within 72 ho iene. rthan "natur It e Madical I	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4o	r 5+)	(Give life. l	dent's Usual Ockind of work do	ne durir	n ng most	of workii	ng		Kind of Bus		ustry	
rland 2	2 should be filed and Mental Hygi Is marked other raumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Percy Kinnier Sc	ott				18.			(First, Middle	, Maide	n Sumame)		
, Mary	and 2 shorally and h		19a. Informant's Name/Relationship (Type Edward L. Beaver/		l		s Address (Sti								,	2090
imore	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic er		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from Stat	e 20b. P	lace of Dispo emetery, cren Metropo Crema	sition (Name on atory or other olitan atory	f place)	1		y 15, 04		Location - C		wn, State Virgin	ia
Balt	permit. Departr Imports any Inju		21. Signature of Funeral Service Cense	Scerl	0	F22	Name and Adan Cis ancis O Unive								, Md 2	0901
	Pnysician /Medical		23a. Part1. Enter the disease, or complications, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that cause cause on each	ed the death line. A f he	n. Do not ent	er the mode of levo hi multi	dying, si	ach as o	d co	r respiratory a	rrest, La	Dig	tee	Approximate Interval Betw Onset and D	/een
8760,	be executed cician and purial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Diseese or injury that initiated events resulting in death) Last	Due to (or a	is a consequ	uence of):	meti	e /	411	wau	n I) c 8	can	0		
.O. Box 68	ne death certif the attending thed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	ic. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3	Ectopic pregna Other (specif)			-			23d. Date Monti		*	ear
Δ.	quires that the signed by all the detact	by	Part II. Other significant conditions con	ributing to death	but not resu	ulting in the ur	nderlying cause	given ir	n Part I.			obacco Yes 2		oute to the	cause of de	eath?
Vital Records,	The law requires that ate has been signed b page 2 should be deta	Completed									24a. Was auto perfo		n de	or to com ath?	sy findings a	vailable use of
of	Attending Physicien: Traction of death. ector: After this certification the funeral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpa 28a. Date of In (Month, D	jury	ER/Outpatien 28b. Time of Injury	28c.	Other: njury at Work?		sing Hon	(Check only one 5 Residence Residenc	dence)	
Division	를 를 들	Certification:	3 Suicide 6 Could not be determined	28e. Place of li building,	njury - At ho etc. <i>(Specif</i> y	ome, farm, str	eet, factory, off	ice		2	8f. Location (City or To	Street a wn, Sta	ind Number te)	or Rural	Route Numb	per,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier Certifying Phys (Check only one) 2 Medical Examir	ician: To the bes er: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred at the	e time, o	date and on, death	place, a	and due to the	cause(date ar	s) and mann nd place, an	ner as sta	ited. the cause(s)	
)	To t To t	M	29b. Signature and title of certifier	lamh			29c. Lid	ense nu 3 C	o 6 L	+1		29d. D	ate signed (Month, D	0ay, Year)	
_			30. Name and address of person who co Ramesh Sabapa	elhi 2	01-10	23a) (Type,	Print) Rek R	ivel	- N	eek	Road	1 /	Balh	Mort	· May	(N
	Sta Registr		31. Date filed (Month, Day, Year) JUL 16 200		strar's Signa	ture 5	Sport	61							212	13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of	Maryland /		artment <i>rtificate</i>			Mental H	ygien Reg. N	000	1.	23050
	Physici		1. Decedent's Name (First, Middle, Last,	Paul	Berdy					2. Date of I Month Jul		^{ay} 2004	Year	3. Time of Death 2:20 A M
	/Medic Examin		4a. Facility Name (If not institution, give		-				cation of Dear	th	4	c. County of	of Death	1
			Potomac Valley Nur			thirds do at	Ro If Under	ckvil	le Under 24 Hrs	0.0.45		Montg		J
П	Funeral Director		5. Social Security Number 6. Sec. 15.	M 2 F	. Age (In yrs. last 57	Yrs.			Hours Min		Sirth Day, Year 8 19	946		place (State or Foreign ntry)
	D		Usual Residence of Decedent		10- Cit. 7		E-41-0-							
	show	-	10a. State 10b. County		10c. City, T			1.					'	0d. Inside City Limits 1 X Yes 2 □ No
	the M	Director	Maryland Montgome	гу		KO	ckvil		-		10n C	itizen of W	hat Cour	
	3a or	<u></u>	1235 Potomac Vall	ev Road				20850				knowr		,
	death ms 2	Funeral	11. Marital Status	12. Was Deced		13. \			anic Origin? (S	Specify Yes or No Rican, etc.)		14. Race	- Americ	an Indian,
36	within 72 hours atter death with the Maryland liene. I then "natural", or Itams 23a or 28a-f show Its Mclical Examination and the modified at	by Fu	1 ★ Never Married 2 Married	Armed Ford 1 ☐ Yes 2 If Yes, Give	□No		ires, speci 1 ☐ Yes 2		Specify:			Specify:	, White, Wh	ite
Ö	hours tural'		3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dat		6a Deced	dent's Usua	I Occupatio		Inknown	16b 1	Kind of Bus		
Maryland 21215-0036	c • W	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4		(Give	kind of worl DO NOT us	k done duri	ng most of wo	orking	100.	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	31110334111	2030.9
212	il Hygiene. other then "	E	Unknown	College (199	501 34)	Unkr	nown				U	nknov	vn	
pu		Be	17. Father's Name (First, Middle, Last)					18	. Mother's Na	me (First, Midd	lle, Maide	n Sumame	9)	
<u>Ş</u>	should be nd Mental marked o	^c	Unknown			105 14-35		(2)		nown	0	· ·	7	
Mai	d2st thanc t7 is n treun		19a. Informant's Name/Relationship (T) Stephen W. Shipley		1					dural Route Num				Ť
	es 1 and 2 should b of Health and Ment fitem 27 is marked r other treumatic	10	20a. Method of Disposition	Admini	20b. Place	of Dispo	sition (Nam	e of		Date		ocation - 0		
Ë	Pages nent of nnt: If it	- 84	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☑ Donation 5 ☐ Other (Specify)	Removal from SI	ale Gate	of E Cemet	natory or oth Heaver	ner piace) 1	Ju. 20	1у 8, 004	Silv	zer St	oring	g, Maryland
Baltimore,	permit. Pages 'Department of H Importent: If ite any injury or of		21. Signature of Funeral Serval Licens	ee •		22	. Name and	Address of D	of Facility			.Be	thes	da-Chevy
<u> </u>	99 = 59		Kafton		M0019	/6 /55)/ Wis	consi	n Ave.,	Bethes	da, N	D 208	314 <u>-</u>	se, Inc. 3501
	Physician		23a. Part1. Éntér the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on ea	used the death. [ch line. IMONIA	Do not ent	er the mode	of dying, s	such as cardia	ic or respiratory	arrest,			Approximate Interval Between Onset and Death 2 days
	/Medical Examiner		resulting in death)		r as a consequen									
В	-	-	Sequentially list conditions, if any, leading to immediate	b	gestive]		Fail	ure						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	_	entia	,								
0,	icate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (o	r as a consequen	ce of):								
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_		/Me	IF FEMALE:	23c. If yes, outco	ome of pregnancy	,						23d. Date	of deline	any.
Вох	death a atten d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Live birt 4□Pregna	h 2 Fetal de nt at time of death	ath 3 □	Ectopic pre Other (spe					Mon		Day Year
P.O.	at the de by the a tached	hys	9 Unknown	9□ Unknov	vn									
Records, F	as this gned be de	þ	Part II. Other significant conditions co	ntributing to dea	th but not resultin	ig in the ur	nderlying ca	iuse given i	n Part I.		tobacco Yes 2	. /		ably 4 Unknown
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I Re	The lav	Com								per 1 Tes	opsy formed 2 N	de	eath?	npletion of cause of
Vital	Physicien: T this certificat ral director, pa	Be C	25. Was case referred to medical examiner?						6. Place of De	ath (Check only	one)			
of \	Physi this c	၉	I Tes ZUNO	Hospital: 1 In		Outpatien				Home 5 Re)
	ling After fune	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month)	Day Year)	b. Time of Injury	M	Bc. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe	a now infr	лу оссиле	a	
Division	of or Attending after death. Director: After d in by the funer	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place o	f Injury - At home g, etc. (Specify)	, farm, str	eet, factory,	office			(Street a		r or Rura	l Route Number,
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in E	O	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exami	sician: To the b	est of my knowle	dge, death	occurred a	at the time,	date and plac	e, and due to th	e cause(s	s) and man	ner as st	ated.
	To the H within 24 To the F complete	Medical	оле)	and manne	r stated.			License nu						Day, Year)
\	To wit		29b. Signature and title of certifier	1,	Michie				075	8	290. 0	7 1 /	10	1//
7	V		30. Name and address of person who c	ompleted cause	Dock of death (Item 23		177		-0	0		116	2/6	14
			Valeria Kleshchel					on Dr	ive. S	ilver Sr	orino	. Mai	rv1aı	nd 20902
	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	sistrar's Signature	8		acks		0		,,	~ - 	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No) 2. Date of Death Month 8. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Year JULY 9, HYMAN 2004 2:30 P BERKOFSKY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 26, 19 Birthplace (State or Foreign Country) **Funeral** Days 1□M 2□F Director NEW YÖRK 090-01-2932 1916 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits r then "naturel", or items 23a or 28a-1 ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No MARYLAND MONTGOMERY ROCKVILLE Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 20853 UNITED STATES 5220 TRAILWAY DRIVE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or ite any injury grother treumatic event, the Medical Examina once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☑ Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 GROCER WHOLESALE GROCERY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) "UNKNOWN" MEYER BERKOWSKY CELIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5220 TRAILWAY DRIVE, ROCKVILLE, MD DAUGHTER ARLENE SILLER, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MT. HEBRON CEMETERY 7/12/2004 FLUSHING, NEW YORK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice se 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death NEYMONIA Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DENENTIA MULTI -INFARCT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELLITUS -2 X No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has 2 No Division of Vital 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. 1 Tyes 2 No investigation after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō To the Hospital within 24 hours a To the Funerel I 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title-of certifier 29d. Date signed (Month, Day, Year) M-0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -n . 31. Date filed (Month, Day, Year) 32 Begistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

HYMAN BURKOFSE

State of Maryland / Department of Health and Mental Hygiene

				Otato of two	zi y iai ia			te of	Death		Reg. No.	01.	22052
	· ·		1. Decedent's Name (First, Middle, Las	(1)				•		2. Dete of De Month	eth Dey	Year	3Time of Daath
	Physici /Medio		Helen Irene Bern	stein						July 1			4:00 P.M.
	Examir		4e Fecility Neme (If not institution, give	street end number)					4b. City, Town, or		h 4c. County	of Deeth	
			Potomac Manor Ca	ire					Potoma		Monte		
I	Funeral Director		5. Social Security Number 6. S 011-10-7608	ex 7. Age ☐ M 2☐ F	9 (In yrs. la:	st birthda Yrs.	y) If Under	Days	Hours Mir	. (Month, Da	th ay, Yeer) 23, 1911	9. Birthp Coun Mas	place (State or Foreign htry) ssachusetts
	p ,	•	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City,	Town or	Location					1	10d. Inside City Limits
	show	2					Location						1 TY Yes 2 □ No
	M M M	Director	Maryland Montgom	ery	Poto	ушас	104.7	p Code			10g. Citizen of V	Mhat Cour	ator?
	uth with the Merylen 23e or 28e-f show		10e. Street end Number 10714 Potomac Ten	nis Lane			20	854			U. S.	Α.	
0	72 hours efter death with the Merylend natural', or items 23s or 28s-f show dies Examiner must be notified at	Funeral	11. Maritel Status 1 ☐ Never Married 2 ☐ Merried	12. Wes Decedent I Armed Forces? 1 Yes 2 X		. 13		_	Hispenic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Specify	ck, White,	
21215-0020	72 hours 'natural',	d by	3 Widowed 4 □ Divorced	Year or Dates:								MI	hite
7	natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dec	edent's Us	ual Occu ork done	pation during most of we d)	orking	16b. Kind of Bu	Jsiness/Ind	dustry
12	within ene.	d E	Elementery/Secondary (0-12)	College (1-4or 5	i+)				cretary		Food Br	okera	age
2	Hygie ther t		12 Years 17. Fether's Name (First, Middle, Last)			DA.	cuci			me (First, Middle			-8-
an	9 10 0 V	Be			Levin	COD			Unkno	own		Unkı	nown
2	should and Men marke umartic	٩	Unknown 19a. Informant's Name/Relationship (re A TII:		ilina Addre	ss (Stree	and Number or F		er, City or Town,		
Maryland	d the		Bruce P. Bernstei	-	1		-		ne, Yorba				
a)	e E		20a. Method of Disposition		20b. Pla	ce of Dis	position (Ne remetory or	me of	200	Date	20c. Location -	City or To	own, State
Baltimore,	permit. Pages Department of H Important: If Ite any injury or ot once.		1 X Burial 2 ☐ Cremation 3 X 4 ☐ Donation 5 ☐ Other (Specify	()		ron l	Memor	ial l	Park :	7/16/200	4 Canto	n, Ma	assachusett
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licer	Stottle	iny	es	Edward 1091 1	l Sag Rock	ess of Fecility gel Funet ville Pil	ke, Rock	ville, M	nc. laryl	and 20852
			23a. Pert1. Enter the diseese, or com shock, or heart failure. List only	plications that caused one cause on each li	the death.	Do not e	enter the mo	de of dy	ng, such as cardia	ac or respiratory a	rrest,	1	Approximate Interval Between
	Physician											1	Onset and Death
all a	/Medical Examiner		Immediate Cause (Final disease or condition	a. ALZHE]	MER'S	DEM	ENTIA					1 1	YEAR
	Lxummer	_	resulting in death)	IIII D II D	Due to (or		equence o):					
	led isit	-F		HYPERT								<u> </u> L	0 YEARS
	death certificate be executed the attending physician and ed for use as the burial-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or	es e cons	equence of):				1	
68760,	siciar buria		Cause (Disease or injury that initieted events	c	Due to for								
89	tificate ig phy as the	Aedical	resulting in death) Last		Due to (or e	a cons	equence of	١٠					
Вох	anding use a	2		d									
Ď	daath cer a attandir d for use	cia	Part II. Other significant conditions of	ontributing to death b	ut not result	ting in the	underlying	cause di	ven in Pert I.	23b. Did	tobacco use co	ntribute to	o the cause of death?
0	tha da by the trached	Physician/	Tarrit officer argitition to officer of	onang to dodan o				3		10	Yas 2 No	3 ☐ Pro	bably 4 Unknown
Ψ,	es that igned to be det	by P											
of Vital Records,	requir been s should	Completed t									an autopsy ormed?	av	fere autopsy findings vallable prior to ompletion of cause death?
Be	The law ate has page 2	E								45	Yas 2XNo	1[□Yes 2ŪXNo
<u>ra</u>			25. Was case referred to medical						26. Place of D	eath (Check only	one)	1	
5	Physician: r this certific ral director,	o Be	examiner?	Hospital:	ent 2 E	B/Outpat	ient 3 🗆 I	OOA O		Home 5□Res		er (Specit	(v)
	Phys r this eral di	-	27. Manner of Deeth	28a. Date of Inju (Month, Da		28b. Time	of	28c. Inju			how injury occur		"
Ö	tending leath.	흹	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y rear)	Injury	М		Yes 2 □ No				
Division	rect rect	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inj building, et			street, facto	ry, office		28f. Location (City or To	(Street end Numb wn, Stete)	er or Rure	el Route Number,
	Hospite 24 hours Funeral tely filla	edical Co	(Check only 2 Medical Exam	yelcian: To the best niner: On the basis of	exemination	ledge, de on and/or	ath occurre	d at the t	ime, dete and plac opinion, death occ	ce, and due to the curred et the time,	cause(s) and ma date and place,	anner as s and due t	stated. o the cause(s)
	the other	Med	one) 29b. Signature and title of certifier	and manner sta	aleu.		2	9c. Licen	se number		29d. Date signe	d (Month,	Day, Year)
	o t i i		he all	20.				D	0053615		July 1		
	-		TIVULIV	J y	looth /tter-	220) /*:	Drint)			- day			
		J.	30. Neme and address of person who DR. ARUNA NATHAN	1	1125 F	Rockv	ille	Pike	, Rockvi	lle, Mar	yland 2	2 085 2	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signetu								
	Regist		JUL 162	004 Den	wa	19	14	ouk	21				

DHMH 16 Rev 6/95

July 12, 2004 Bishop, brace E

***		1 - For State Registrar	State of Maryland /	Department of H Certificate of L	Death	Reg. No.	23853
Physici /Medio		Decedent's Name (First, Middle, Last) GRACE	E. BISHOP		2. Date of Month JUL	Day Year	8:40 A
Examin		4a. Facility Name (If not institution, give s Suburban Hospi	treet and number) tal	Bethe		4c. County of Deat MONTGON	TERY
Funeral Director		220 20 4244	M 2対F 7. Age (In yrs. last b	Yrs. If Under 1 Year Months Days	Hours Min. 8. Date of (Month)	of Birth b, Day, Year) 2 24,1931 F	pplace (State or Foreig untry) laryland
Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Monto		wn or Location Silver Spri	ing		10d. Inside City Limits
th with the 23a or 28s	al Director	10e. Street and Number 901 Briggs (Chaney Road	10f. Zip Code	905	10g. Citizen of What Co	
72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dizal Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 XNo	spanic Origin? (Specify Yes on, Mexican, Puerto Rican, etc Specify:	or No- 14. Race - Ame Black, White Specify: B]	e, etc.
ad within 72 hours afi giene. er than "naturel", or the Medical Exam	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th	cation 16a Completed) College (1-4or 5+)	a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired Section	furing most of working	16b. Kind of Business/	ŕ
d be file	To Be Co	17. Father's Name (First, Middle, Last) Alvin B. Mat	thews		18. Mother's Name (First, Mi	iddle, Maiden Sumame)	
nd 2 sh ilth and 27 Is m r treum	-	19a. Informant's Name/Relationship (Type Eunice Bishop	(Daughter)	901 Briggs	and Number or Rural Route N. Chaney Rd.,	Silver Spr	ring, MD
permit. Pages 1 ar Department of Hea Importent: If Item any Injury or othe		20a. Method of Disposition **Surial 2 Cremation 3 R * 4 Donation 5 Other (Specify) 21. Synatur Funeral Service Lights	emoval from State cemet				ing, MD
Fhysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heaft failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	onot enter the mode of dying	g, such as cardiac or respirato		Approximate Interval Between Onset and Death
icate be executed physicien and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or friery that initiated events resulting in death) Last	Due to (or as a consequence				
The law requires that the death certificate be enter has been signed by the attending physicien age 2 should be detached for use as the buris	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12/months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3□Ectopic pregnancy 5□ Other (specify)		23d. Date of deli Month	very Day Year
sicien: The law requires that I certificate has been signed by rector, page 2 should be deta	þ	Part II. Other significant conditions cor	ntributing to death but not resulting	in the underlying cause give		Did tobacco use contribute to	the cause of death?
The law requate has been page 2 should	Completed					autopsy prior to d performed? death?	topsy findings available completion of cause of
Physician: this certific ral director.	To Be	27. Manner of Death		Time of 28c. Injury	at 28d. Description	nniv one) Residence 6 Other (Specifies how injury occurred	iify)
l or Attending I after death. Director: After d in by the funer	Certification;	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)		Yes 2 □ No 28f. Locati	ion (Street and Number or Ru r Town, State)	ral Route Number,
To the Hospitel or At within 24 hours after o To the Funerel Direct completely filled in by	Medical Cer		sician: To the best of my knowledger: On the basis of examination a and manner stated.				
To the comple	Me	29b. Signature and title of certifier	MD	29c. Licenso	51616	29d. Date signed (Month 07-12-2	400
		30. Name and address of person who con NELSON KALIL 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23a	\ \	0 #32P Ola	Jey, MD 20	832
Sta Regist	rar	JUL 15 20		& Sports			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 6:50 P M Ju₁v 11, 2004 Barbara Brauer Ann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5404 Spruce Tree Avenue Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 ☐ M 2 🖺 F 66 Yrs. 18, 1937 Illinois 342-30-8733 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Tyes 2 No Director Md. Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5404 Spruce Tree Avenue 20814 U.S.A. death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after I □ Yes 2 🔯 No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Psychologist/Director Mental Health Center other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event pnce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Brauer Lillian Carlson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5404 Spruce Tree Ave., Bethesda, Maryland 20814 Allen Sussman/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition July 12, 2004 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Linse 10 East Deer Park Dr. Gaithersburg, Md. 20877 halle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Endometrial Carcinoma 13 Months /Medical Due to (or as a consequence of) Examiner Liver Metastasis 13 Months S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) Box 68760, by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 🖸 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2🔯 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after death.
I Director: After this of in by the funeral d 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) and title his DC5244 July 12, 2004 10 30. Name and address of person who completed cause of death (I em 23a) (Type, Print)

Registrar

State

Harold S. Mirsky, M.D.

13 2004

31. Date filed (Month, Day, Year)

JUL

32. Registrar's Signature

730 24th Street. N.W. #7 Washington, D.C. 20037

	1 - State	artment of Health and Mental H	2001
	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of I	Reg. No. 1 2 0 5 5
Physician	Gloria Evans Burr	Month	13, 2004 Year 8:45 a M
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Examiner	Suburban Hospital	Bethesda	Montgomery
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Date of E	
Director	233.40.52/6		9,1927 Davis, W.V.
and	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
death with the Maryland rms 23a or 28a-f show roust be notified at neral Director	MD Montgomery Bethesd	а	1 ☐ Yes 2X No
inter death with the Mar tritems 23a or 28a-f si inter must be notified Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
h with	6108 Dunleer Court	20817	U.S.A.
ems ?	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or North Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
36 or Its	1 Never Married 2 Married 1 Yes 2 MNo	1 Yes 2 XNo Specify:	Specify: White
OO3(3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Dece	death Havel Convention	
15.	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
21215-0 ed within 72 ho ygiene, "neturing the Midical I t, the Midical I Completed	Elementary/Secondary (0-12) College (1-4or 5+)	okkeeper	Waggaman-Brawner Realty Corp.
ind be filed tall Hyg dothe	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	
Vlau build b Ments arked arice	Roland Evans	Twila Wilt	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in the Marylan I filem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified at once.		ng Address (Street and Number or Rural Route Num	
e, L I and Health om 27 her to	Charles Burr, Jr./ Husband 6108 20a. Method of Disposition 20b. Place of Dispo	Dunleer Court Bethesda	Maryland 20817
To Figure 7	1 Burial 2 □ Cremation 3 □ Removal from State	matory or other place)	20c. Location - City or Town, State
Him Fire Part Andrews		2. Name and Address of Facility Joseph Ga	Washington DC
De man permanan perma		130 Wisconsin Avenue NW	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory	Interval Between
Physician	Immediate Cause (Final disease or condition Multiple Myelon	ma	Onset and Death 2 years
/Medical Examiner	resulting in death) Due to (or as a consequence of):		
RESIDENCE OF THE PARTY OF THE P	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
D, executed an and rial-transit Examiner	Cause. Enter Underlying		
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
8760, cate be exphysician the burial	d		
68 tifficat ng phy as th	To a series of the series of t		
3,200H 15 am P.O. Box 6 nat the death certifi d by the attending fetached for use as	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	⊒Ectopic pregnancy	23d. Date of delivery
ords, P.O. Bordels, P.O. Bordelies that the death east signed by the atternould be detached for usted by Physiciar	1 Yes 2 2No 4 Pregnant at time of death 5	Other (specify)	Month Day Year
P.O.P. Date the date the setached	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the u	underkring equal grupp in Part I 220 Dir	I tobacco use contribute to the cause of death?
Suly 13, 2c But Sords, P.O. vrequires that the deen signed by the should be detached	Pulmonary Hypertension		Yes 2500 3 Probably 4 Unknown
or requestional	1 11	:	777
Vital Record sician: The law requir certificate has been s rector, page 2 should	Congestive Heart Failure	24a. Wa aut	24b. Were autopsy findings available prior to completion of cause of death?
tal I	25. Was case referred to medical		XX No 1 Yes 2 No
of Vital Rec Physician: The lav this certificate has ral director, page 2.	examiner? 1 ☐ Yes 2 🕅 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death (Check only	sidence 6 □Other (Specify)
Slovidination of V transfer dash. ctor: After this ce y the funeral directions of the funeral direction; To E	27. Manner of Death 28a. Date of Injury 28b. Time o	TO THE PERSON OF	e how injury occurred
sior sior andin path. or: Aft	2 Accident investigation	M 1 Yes 2 No	
Division of the formal of the	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)
DIVI: Divi: rospital or Atti hours after d ivineral Direct siy filled in by I			
Division of V To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral director. Medical Certification; To E	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, deatly one one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.		
To th withir To th comp	29b. Signature and title of cettifier	29c. License number	29d. Date signed (Month, Day, Year)
1.5	P~010	D29675	July 14, 2004
	30. Name and address of person who completed cause of death (Item 23a) (Type,		
CARTA	Ralph Boccia, M.D. 6420 Rockledge Dr 31. Date filed (Month, Day, Year) 32. Begistrar's Signature		20817
State Registrar	JUL 16 2004 Serve B	Sparks	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 03:45 M Delbert Thomas Cooper /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Hilegan Heart iumber land barrox If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 11X M 2□ F Yrs. Director 73 215-26-6424 1931 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Allegany Cresaptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Itams 23a 14813 McMullen Highway 21502 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ges 1 and 2 should be filed within t of Health and Mental Hygiene. If itam 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 9th Foreman Auto Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilbert Thomas Cooper Edith Bessie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Twila L. Cooper/wife 14813 McMullen Highway, Cresaptown, Md. 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Deer Park Cemetery 7/18/04 Deer Park, Maryland 21. Signature of Funeral Service [1 22. Name and Address of Facility Stewart Funeral Home Busy 32 S. Second St., Oakland, Md. 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Examiner ARTERIOSCUTIONC CARDIOVAP CULAR DISTASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the use as t IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 1 MG Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 atural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To tha Funaral Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide cal 29a. Certifier 10 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the of certifier 29b. Signature and til PITYSICOM 30. Name and/address no completed cause of death (Item 23a) (Type, Print) 912 SETON DRIVE CUMBERLAND MD 21502 LOVERIA JR. 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5:35 AM Jarles 1,2004 Ac. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Higgins Faston
If Under 1 Year If Under 24 Hrs. Street Talbot 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 218-20-814 12M 2□F Months Days Hours Min. Yrs. 1926 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🗷 No MD aroline Reston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA DRIVE DRUMMER 21655 12. Was Decedent Ever in U.S. Amed Forces? 1 Ves 2 No ///945 If Yes, Give Year or Dates: ////946 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Black 11/1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Harriett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5571-DRUMMER DRIVE-PRESTON, Mary brud 21655 orothi 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 19/04 ^¹ 4 □ Donation 5 □ Other (Specify) Veteran's Cemetery HURIOCK, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Henry Funeral Home, P. A.
510 washington St. Cambridge MD.21613 23a. Part 1. Enter the disease, or complications that caused the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Calcena Von Small Cell lling IVr. 6months Due to (or as a consequence of): Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Completed by Funeral Director

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Funeral

Director

Examiner anding physician and use as the burial-transit Physician/Medical been signed by the should be detached Medical Certification; To Be Completed by cate has page 2 s within 24 hours after death To the Funerel Director: completely filled in by the

29a. Certifier

or Attending Physician: The law requires that the death certificate be executed

this

death.

fo the Hospitel

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred nouse 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29c. License number 3988

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

29466 Pintail Drive, St. 5, Easton, MD 21601 David H. Smith, M.D., 31. Date filed (Month, Day) (Par) 1 2004². Registrar's Signature

State Registrar

			1 - For State Registrar		_	Maryla		artmen rtificate				lental Hyg	iene () () 4	238	159
	Physici	an	1. Decedent's Name (F	First, Middle, Las	it)							2. Date of Deat Month	h Day	Year	3. Time	of Death
	Physici /Medi Examir	cal	Marshall I 4a. Facility Name (If no			er)		4b. City,	Town, or	Location of	of Death	July 11			1:0	0 P ^M
			4621 Drumm						vy C					ontgo	m 0 20 17	
1	Funeral		5. Social Security Number	ber 6. S	ex 7.	Age (In yrs	. last birthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day,	Voarl		place (State ntry)	or Foreign
	Director		243-20-7650 Usual Residence of De)	X M 2□ F	81	Yrs.	WOILIS	Days	Hours	MIIII.	May 14,	1923_	Durk	nam, N	1C
	rylan thow	_	10a. State 10	b. County		10c. C	ity, Town or Lo	cation							10d. Inside	City Limits
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	iten de	Funeral Director	11. Marital Status 1 ☐ Never Married	2Ñ Married	12. Was Decede Armed Force 1 XYes 2[is?	J.S. 13. 1	Was Deced Yes, spec	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	etc.	
980	ors at	by	3 Widowed 4		If Yes, Give Year or Date:	sWWII		1 ☐ Yes 2	ON	Specify:			Specif	v: Wh:	ite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or flems 23a or 28e-1 show that the Medical Examiner roust be mailied at	Completed	15. (Specific	. Decedent's Ed	ucation		16a. Dece	ent's Usua	І Оссира	tion		1	6b. Kind of B	usiness/In	dustry	
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and	be fi	Be	17. Father's Name (Firs									(First, Middle, M		ne)		
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28e-f show amportent: If item 27 is marked other than "neturel", or items 23a or 28e-f show amportent: If item 27 is marked other treumetic event. The Marical Examilised or other treumetic event. The Marical Examilised or once.		Dorothy G			2	4621	Drumm	ond	Ave.	Che	y Chase	MD 2	3815	Code)	
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	Physician /Medical Examiner		Immediate Cause (Fina disease or condition resulting in death)	al	a. Idior Due to (or a	oathic as a consec	Pulmo				cardiac o	r respiratory arres	st,	1	Approxima Interval Be Onset and O yea:	tween Death
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical Examiner	Sequentially list condition if any, leading to immercial the condition of	ry	Due to (or a											
.O. Box 6	death certifi e attending I id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 Yes 2 No 9 Unknown	nths?	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	al death 3 🗌	Ectopic pre Other (spe					23d. Dat	e of delive nth		Year
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ğ	w require been sig should b	edt	Diabetes	Mellit	15							1 🗆 Yes	2 No	3 Proba	ably 4 🗆	Unknown
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<u> </u>	Physicien: r this certifica ral director, p	Be c	25. Was case referred to examiner? 1 ☐ Yes 2 ☐ X to	100	Hospital:							(Check only one)	-	-		
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Division of	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:		Could not be determined	28e. Place of lubuilding, e	njury - At he etc. (Specif	ome, farm, stre	et, factory,	office		2	8f. Location (Stre City or Town,	et and Numbe State)	er or Rural	Route Num	ıber,
	e Hospitel 124 hours a e Funerel I letely filled	edical	29a. Certifier 1 (Check only one)	Certifying Phy Medicel Exam	sician: To the bes ner: On the basis and manners	of examina	owledge, death ition and/or inv	occurred a estigation, i	the time n my opir	, date and nion, death	place, a	nd due to the cau d at the time, date	se(s) and mai a and place, a	nner as sta ind due to	ited. the cause(s	3)
	To the Hos within 24 h To the Fur completely	Me		of certifier	/ mainers			29c.	License i	number		29d	. Date signed	(Month, E	ay, Year)	
•	- > - 3		1 (10	tox	Tunn	11	W)	D320	33			ıly 12,			
	5		30. Name and address	of person who co	empleted cause of	death (Iten	n 23a) (Type, F	Print)								
_			Peter Hamm						Cha	se, M	ID 20	815				
1	Sta Registr	-	31. Date filed (Month, D		32. Degis	trar's Signa		,	KN							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2004 Year **Physician** July Margarita Cartagena 9, 7:35 рм /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Sept. | 19, 1926 9. Birthplace (State or Foreign Elusian Salvador 5. Social Security Number 579-82-8424 7. Age (In yrs. last birthday) 77 Yrs. **Funeral** 1 M 2X) F Yrs. Director Usual Residence of Decedent Pages t and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23s or 28s-f show treumatic event, the Medical Examinat must be notified at Maryland Montgomery 1 Yes 2 No Silver Spring Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12220 Selfridge Road 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Yes 2 No Specify: Salvadoran Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 11 Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felix Cartagena Dominga Mejia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rolando Al Cartagena/ Son 12220 Selfridge Road, Silver Spring, MD 20906 other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State July 12, Metropolitan other place) ō 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department of Important: # eny injury or once. 0 2004 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) Crematory 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between On et and Death Immediate Cause (Final volangiocarc **Physician** disease or condition resulting in death) MO /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 16 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an performed 1 Yes 2 010 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 100 1 Impatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 ANatural 5 Pending death. 1 ☐ Yes 2 ☐ No after death Director; 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 24 hours a To the Funeral (completely V

Cartagena, Margarita 7/9/04

Baltimore, Maryland 21215-0036

Registrar

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

Frederick G. Barr, M.D. 5454 Wisconsin Ave.; Chevy Chase, MD 20815 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

022775

29d. Date signed (Month, Day, Year) 7-10.04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Ireland Caudill /Medical July 12, 2004 6:45 Α 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth Brook Grove Nursing Home Olney Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) Months Days 1₩ 2□F Hours 278-03-6721 89 Yrs Director June 10, 1915 Kentucky Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow or other traumetic event, the Madical Examinativity was be notified at Director Yes 2 No Maryland | Montgomery 01ney 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö 18430 Brook Grove Rd. or items 23a Funeral 20832 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian iit. Pages 1 and 2 should be filed within 72 hours after of the aith and Mental Hygiene.
Itant: If item 27 is marked other than "natural", or iten inlury or other traumatic event, the Medical Exercise. Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 ▼ No Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manufacturing Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wattie Caudill Julia Caudill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Apple Grove Rd. Silver Spring, MD 20904 Gordon Caudill-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) 7-14-2004 Chester Twp., OH Western Reserve M.G. permit. Deportm Importar any nju 21. Signature of Funeral Service Licentee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final ASPIRATION **Physician** HIVELL MONIA disease or condition resulting in death) DAYS /Medical Due to (or as a consequence of): Examiner DYSPHAGIA + WEEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed andir g physician and use as the burial-transit ACILTE CEREBRAL INFARCT I WEEK that initiated events resulting in death) Last Due to (or as a consequence of) attendir g physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of detivery 3 Ectopic pregnancy Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signe page 2 should be Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1 Yes 2 No or Attending Physicien: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 25 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide in by I 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the ! and manner stated.

State Registrar

29b. Signature and title of certifier

HOWE 31. Date filed (Month, Day, Year) 32. Registrar's Signature 15 2004 JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MASITSA WILLIAMSPORT

29c. License number

A33700

29d. Date signed (Month, Day, Year)

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7004

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Baltimore, Maryland 21215-0036

Box 68760.

P.O. 1

Division of Vital Records.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

1 2 2004

souls

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** 1:18 A.M 11, 2004 Alta G. Couch July. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 1 M 2 TF Yrs. 98 28, 153-26-2823 Director Nov. 1905 New Jersev Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic avant, the Medical Examiner rust be notified at 1 ☐ Yes 2 No Director Maryland Montgomery North Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? With ō Itams 23a 5550 Tuckerman Lane 20852 United States Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status □Yes 1 Never Married 2 Married 2 X No ŏ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Charles Robert Graham 0 Olive Morrell Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13428 Query Mill Road, North Potomac, MD. 20878 Bruce W. Wolff/Son itam 27 l 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State ō = 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State July 15, permit. Page
Department of
Important: If
any injury or 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 2004 Crematorium, Inc. 22. Name and Address of FacilityRohert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Salvice L M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician days disease or condition resulting in death) oneumonia /Medical Die to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physiclan/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. ф be detached 9 Unknown 9 🗌 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 255 No autopsy 1 Yes 2 No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the To the 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number D59738 Moln MO July 11, 2004 30. Name and dress of person who completed cause of death (Ithin 23a) (Type, Print) center Drive Rockville, MD 20850 9901 Medical Alici Mist a 31. Date filed (Month, Day, Year)

JUL 15 21 Registrar's Signature.

Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 12, July 2004 4:45 P. Marilyn R. Cummings /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 16, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 9. Birthplace (State or Foreign 1□M 2□ Months Days 1930 Yrs. 74 Washington, D.C. Director 215-46-4075 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other then "netural", or Items 23e or 28a-f shov other treumatic event, It's Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 10403 Leslie Street U. S. A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify: à Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene. Importent: If tem 27 is marked other then ", any injury or other treumatic event, the Magnet. Elementary/Secondary (0-12) College (1-4or 5+) Years Librarian U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Reiskin Elizabeth Abrams ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Wyant - Daughter 10705 Graeloch Road, Laurel, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State B'Nai Israel Cong. 7/15/2004 Oxon Hill, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc.
1170 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licenses Sonald 23a. Part1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 HOURS ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** ACUTE GASTROINTESTINAL HEMORRHAGE 4 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit certificate be executed Due to (or as a consequence of): attending physician Physician/Medical the ! as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RESPIRATORY FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? RENAL FAILURE 24a. Was an page 2 s has autopsy performed? Yes 2 No HEMOLYTIC ANEMIC 1 Yes 2 🗆 No 1 Yes Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျှ 1 Tyes this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a, Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dato and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Saltimore. Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar

31. Date filed (Month, Day, Year)

JUL 16 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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п	Physici		John W. Clark	Lasiy					Month July		OO4 Year	4:10	aM
	/Medic Examin		4a. Facility Name (If not institution, Shady Grove Ad	give street and nu ventist	_{Imber)} Hospita	al.	4b. City, Town, or Rockvi			4c. C	ounty of Death Montgon)	
-	Funeral		5. Social Security Number	6. Sex	7. Age (In yr.	s. last birthday)	If Under 1 Year	If Under 24 Hrs		th	9. Birth	nplace (State o	r Foreign
и	Director		268-12-7938	1 3 M 2□ F	85	Yrs.	Months Days	Hours Min	Oct. 5	, 1918	Col	intry) rida	
	put &		Usual Residence of Decedent 10a, State 10b, County		10c (City, Town or Lo	cation					10d. Inside Ci	ite Limita
	Maryle f sho	or		tgomery	155.	Rocky	_					1 Tes	•
	28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	untry?	
	th with	a D	5812 Ridgeway	Avenue			2085	1		USA	A		
ထ္	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "naturat", or Items 23a or 28a-f show event, the Medicul Evarth or roust be inclined at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed Fo	2 No		Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (\$ in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		. Race - Amer Black, White	, etc.	
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<u>lar</u>	should be nd Mental marked o	To E	Thomas Bell C	lark				Olive	Bernice	e Sco	vell		
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		1 🗆 Burial 2 🗵 Cremation			Metropo	gique plac	· 1	1 ^{Pgte} 14,		tion - City or T		n i n
Ē	artme ortani		 4 □ Donation 5 □ Other (Special Service Line) 21. Signature of Funeral Service Line 		0	Crema						Virgin	пта
Ba	Dep Imp	1	> William	J By	<u> </u>	50	Name and Address J.	sity Blv	d. W., S	Silver	Inc. Sprin		
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			30. Name and address of person w		se of death (Ite	em 23a) (Type,							
			Carl Schoenberg 31. Date filed (Month, Day, Year)		5220 Fr Begistrar's Sign		0		urg, MD	20877	7		
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		RegistraMFND#14PerFH7/ 1. Decedent's Name (First, Middle, Last)		Ce	rtificate of	Death	2. Date of De	Reg. No. U	3. Time of Death
Physicia /Medic		ALVARO	DEJESUS	CRUZ			July 9	Day 2004	Year 07:31A M
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Function	8.	12750 Layhill Roa 5. Social Security Number 6. Sec		yrs. last birthday)	Silve:	r Spring	8. Date of Birt	Mc	ontgomery 9. Birthplace (State or Foreign
Funeral Director			M 2□F 58	Yrs.	Months Days		OCt. 2	1,1945	S. America
and		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
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ler dea	by Funerai	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer Specify: I	Specify Yes or Note to Rican, etc.) Iispani	Blaci	American Indian, K, White, etc.White Hispanie
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2 sho and lama	To	19a. Informant's Name/Relationship (Ty Marina Cruz (W		19b. Mailir 1005	ng Address (Stree Fairv	tand Number or Ri iew Ave.	ural Route Number	or, City or Town, S Ma Park	State, Zip Code) MD 20912
har har		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of natory or other pla	ace)	Date	20c. Location - 0	City or Town, State
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8760, rate be executed hysician and the burial-transit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
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.O. Box the death cert y the attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify) _	cy		23d. Date Mon	of delivery th Day Year
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T ge ag		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Inju	4 Nursing F		ow injury occurre	
Division I or Attanding after death. Diractor: After	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)			28f. Location (S City or Tow	treet and Numbern, State)	r or Rural Route Number,
	edical C	29a. Certifier 1 ☐ Certifying Physical (Check only one) 1 ☐ Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exa and manner stated.	knowledge, death	occurred at the to	ime, date and place opinion, death occu	n, and due to the corred at the time, co	ause(s) and man late and place, ar	ner as stated. nd due to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier			29c. Licen	se number	2	29d. Date signed	(Month, Day, Year)
20		· Carol Ho	Ulann	d	0.C.	M.E.		July 10,	2004
•		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	•	ann Stand	h pales	70.00 M	ryland 21201
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's S		Spork		ri natrii	we, Ma	+y+a1K1 21201

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND#20b, openFH7/13/04, BW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** RICHARD CURBEAN Jr. 7,2004 JULY 2:52P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Laurel 8. Date of Birth (Month, Day, Year)
Dec. 8,1929 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours XXM 2 F 74 Yrs. 250-42-7937 Carolina Director Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show any july to other traumatic event, If a Marylan Exerciting Language. 1X Yes 2 □ No Director MD Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8716 Chestnut Ridge Drive 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 22 No If Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3rd Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Curbean, Sr. Viola Russell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Mae Curbean (Wife) 8716 Chestnut Ridge Dr., Laurel, MD 20707 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State Memory Crematory of other place)
With the Carolina Blackstock, S.Carolina Blackstock, S.Car 1 Burial 2 □ Cremation 3 Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A gna, re of Funeral Service Licensee 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? The law autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3K DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. Jope, MD 22840 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) Dr. Hazel M Tape, MD 12201 Plum Orhard Dr Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature State racks JUL 13 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

				State of Ma	aryıanı		artment of F <i>tificate of</i>		•	00	0.1	arte de
	*		Decedent's Nama (First, Middle, Last)			Cei	lilicate Ui	Dealli	2. Data of De	Reg. No.	U4	3. Time of Death
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	/Medi Examir		4a Facility Nama (If not institution, give s			1			r Location of Death		_	
				eets Nu	ursin 4	Home		Dafla			rett	
	Funeral		5. Social Security Number 6. Sex		a (In yrs.	ast birthday)	If Undar 1 Yaar Months Days	If Undar 24 H	n. (Month, Da	lh y, Year)	9. Birthplac	ce (State or Foreign
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	th the 28 28 28)Irec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country	17
	23a	Funeral Director	706 East Alder	Street			21550			U.S.		
	er de	une		12. Was Decedent I Armed Forces?		5. 13. V	Vas Decedent of H Yes, specify Cubi	lispanic Origin? (an, Mexican, Pua	Specify Yas or No into Rican, atc.)	- 14. Rad Bla	ce - Amarican	
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Ma	C/ c/ 20 20	1	19a. Informant's Name/Relationship (Type Robert Shaffer	ю, Pnnt)					Rural Route Numbe Friends	-	•	
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Baltimore,	mit. I spartm sportar iy Injui	- 1	21. Signature of Funeral Sarvice Licente	e	Ozni	22.	Nama and Addres	ss of Facility	-		ganto	W11, WV
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n C	After I	ig	27. Mannar of Death 1 Matural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 2	28b. Time of Injury	28c. Injun Work		28d. Dascribe h	ow injury occurr	ed	
<u>s</u>	Attending Physician: or deeth. ector: After this certific by the funeral director,	lcat	2 Accident investigation 3 Suicide 6 Could not be	28a. Place of Inju	ry - At hon	ne farm stre		Yes 2 □ No	28f. Location (S	treet and Numb	er or Rural R	oute Number
<u>S</u>	after Dire d in b	Certification:	4 ☐ Homicide determined	building, etc.					City or Tow			
	To the Hospital or Attending Physician: The is within 24 hours after deeth. To the Funeral Director: After this certificate ha completaly filled in by the funeral director, page	Sal	29a. Certifiar 1 Certifying Physi (Check only 2 Medical Examin	cian: To the best of	my know	ledge, death	occurred et tha tim	na, data and plac	e, and due to the o	ause(s) and ma	nner as stete	d.
	the Hin 24 the F.	ledical	one)	and manner stat	examinatio ted.	and/or inve						
	Vit To 1	Σ	29b. Signatura and title of certifier	′/			29c. License		7	29d. Data signed	(Month, Day	r, Year)
			· Wandy	arma	-	MD	DO	025	159	1 114 13	, 200	ゲ
			30. Name end eddress of person who con Walter K. Nay	ipleted cause of de	ath (Item 2	23a) (Type, P	rint) Ru~ 24	7 A	759 dent M	1 1 2 /5	20	
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	Dhusia	on	1. Decedent's Name (First, Middle, Las	t)					Date of Death Month	Day	Year	3, Time o	f Death
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	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	vn, or Location of	of Death		4c. County	of Death		
			Shady Grove Adver	tist Hospit	tal	Rock	ville			Mont	gome	ry	
	Funeral		Social Security Number 6. S		In yrs. last birthda		ear If Under	24 Hrs. 8. [Min.	Date of Birth Month, Day, Ye	ar)	9. Birthp	place (State ontry)	or Foreign
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	pu *		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or								
	aryla shov	-	Toa. State	1'	oc. City, Town or	Location					1	10d. Inside C	
	8e-f	ctc	Maryland Montgome	ry	Gaither	sburg							2 □ No
	or 2	Dire	10e. Street and Number			10f. Zip Co	de		10g.	Citizen of V	Vhat Cour	ntry?	
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	tems	Funeral Director	11. Marital Status	12. Was Decedent Eventh Armed Forces?	1070	. Was Decedent If Yes, specify	of Hispanic Original Cuban, Mexican	gin? (Specify	Yes or No- n, etc.)		e - Americ k, White,	can Indian,	
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d 2	be filed within 72 hours after death with the Marylan Ital Hygiene. od other than "naturel", or Items 23a or 28e-f show event. If a Medical Exercities in a si be notified at		17. Father's Name (First, Middle, Last)		58	iresman	18 Mothe	er's Name (Fir	st, Middle, Maid	ateri			
an	od be	Be c	Simpson	Delph			10111101110		_		Ĺ.		
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	40240		23a. Part1. Enter the disease, or comp	.2000		0 East 1				ersbur	g, M		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Ventricul Due to (or as a c	ar Fibri consequence of): Cardiomy	llation	dying, such as t	cardiac of 163	piratory arrest,			Approximat Interval Bet Onset and I	Death 1tes
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.O. Box 6	death certifi e attending id for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of ₁ 1□Live birth 2 [4□Pregnant at tim 9□ Unknown	Fetal death 3	□Ectopic pregna□ Other (specif)				23d. Date Mon		_	/ear
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⋚	Physicien: this certific ral director,	8	examiner?	Hospital:	4E500			of Death (Che					
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vis	I or Attendation after deation Director:	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury		treet, factory, off	ice	28f. L	ocation (Street	and Numbe	r or Rural	Route Numl	ber,
Ö	el or s afte of in	Sert	4 El Homolde	building, etc. (<i>Бреспу)</i>				City or Town, Sta	ite)			
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only one) 1X Cartifying Phyone) 2 Madical Exam	rsician: To the best of mine. On the basis of ex	amination and/or in	th occurred at th	e time, date and ny opinion, death	d place, and d h occurred at	ue to the cause the time, date a	(s) and man	ner as stand due to	ated. the cause(s)	
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	N		× 21-1/1	1.06	e, 11		26540		T ₁	ıly 8,	200	4	
1	041		30. Name and address of person who d	ompleted cause of death	(Item 23a) (Tyne		20070		J	- Ly 0 9	200	7	
			Carl I. Schoenberg			•	Road. #	213.	Saithers	sburg.	MD.	20877	7
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's				,		01			
	Registr		JUL 12 200	4 Sprew	0	Spark	2						

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examinational Permitting once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registrar		(Certificat	e of [Death		Reg. No.	004	23870		
	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	Year	3. Time of Death		
ian cal	TIMOTHY	MARK	DAY				JULY	8,	2004	5:24 P M		
ner	4a. Facility Name (If not institution, giv	e street and number))	4b. City,	Town, or	Location of Dea	ath	4c.	County of Dee	eth		
	SHADY GROVE ADVEN				OCKV				MONTGOM			
	5. Social Security Number 6. S 266-47-6029 Usual Residence of Decedent	DM 2DE	ge (In yrs. last birth	Months	Days	If Under 24 Hi Hours Mi		$\frac{1}{y}$, Year)	9. Bir	thplece (State or Foreign ountry)		
	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits		
ţō	MARYLAND MONTGOM	ERY	GAITHE	RSBURG						1 ☐ Yes 2 ☐ No		
rec	10e. Street and Number			10f. Zip	Code			10g. Citiz	zen of What C	ountry?		
Funeral Director	9150 CENTERWAY RO	AD			208	79		UNT	TED ST	'ATES		
Jere	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dece	dent of His	spanic Origin?	Specify Yes or No	- 1	14. Race - Am			
by	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 Y If Yes, Give Year or Dates:	No	1 ☐ Yes		Specify:	erto Rican, etc.)		Black, Whi	WHITE		
Completed	15. Decedent's E. (Specify only highest gra		16a. C	Decedent's Usua	al Occupa	ition uring most of w	orkina	16b. Kir	nd of Business	Industry		
pie	Elementary/Secondary (0-12)	College (1-4or		life. DO NOT u	se retired))	Unking					
lo E		1_	CAR	PENTER/		WALL ME			NSTRUCT	ION		
Be	17. Father's Name (First, Middle, Last					18. Mother's N	ame (First, Middle,	Maiden				
ုင္	KENNETH	DAY	7			PAULI	NE		KIN	DER		
	19a. Informant's Name/Relationship (Type, Print)					Rural Route Numbe					
	JULIA B. DAY, WI	FE				ROAD,	-			AND 20879		
20a. Method of Disposition 1												
	21. Signatule of Funeral Service Lice	600			SKY-	GOLDBER	G MEMORIA KE, ROCKV			INC. 20852		
	23a. Part1. Enter the disease or com	plications that cause	d the death. Do no						1, 110	Approximate Interval Between		
	shoot, or heart fail fe. List only Immediate Cause (Final			DICEAC	T					Onset and Death		
	disease or condition resulting in death)	a	RY ARTERY a consequence of		Ľ					6 MONTHS		
		HYPERTH		,								
ē	Sequentially list conditions, if any, leading to immediate	D	a consequence of):								
Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events											
	resulting in death) Last	Due to (or as	a consequence of):								
ical		d										
Medical	IF FEMALE:											
	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic p				2	3d. Date of de Month	livery Day Year		
by Physician	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of death	5 Other (sp	pecify)					-u,		
Ph	Part II. Other significent conditions of	contributing to death (out not resulting in t	he underlying o	ause dive	n in Part I	23e. Did to	obacco us	se contribute t	o the cause of death?		
by	SMOKING, HYPER			, ,			1[X)	/es 2□]No 3∏P	robably 4 Unknown		
ete							24- 146-		045 111			
Completed							24a. Was autor perfo	SV	prior to death?	utopsy findings available completion of cause of		
	05.146							med? 2 X No	1 Yes	2 □ No		
Be C	25. Was case referred to medicat examiner? 1 XYes 2 No	Hospital:	ent 2 XER/Outp		Othe	-	eath (Check only o					
5.	27. Manner of Death	28a. Date of Inju (Month, Da			JA	4 Nursing	Home 5 ☐ Resid			ocify)		
ţ	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio		ay Year) Inj	ury M	8c. Injury Work 1 □ Y	? ′es 2 □ No		, ,				
fica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of In	jury - At home, farn	n, street, factor	, office		28f. Location (S	Street and	i Number or R	ural Route Number,		
erti	4 Homicide	building, e	tc. (Specify)				City or Tov	vn, State)		·		
27. Manner of Death 1												
29b. Signature and title-of-certifier 29c. License number 29d. Date signed (Month, Day, Year)												
	199	m.C)_	7	100	0590		7/0	3/20	1850		
	30 Name and address of person who	completed cause of	death (Item 23a) (T	vpe, Print)	15	225	Shoot	en C	\$ -0	0 001		
	31. Date filed (Month, Day, Year)	in Flu	lu den	iev,	#	305	208	15	5	- 74		
ate rar	JUL 13 20	N4 2	var B	100	uks	/						

			1 - For State Registrar	State of	Maryland	-	artment rtificate				ental F	lygiene Reg. No	1000	238	71
	Physici	an	1. Decedent's Name (First, Middle, L.								2. Date of Month		ıy Year	3. Time of	Death
	/Medic		Ernest H. Dave								July		2004	8:51	РМ
	Examir	er	4a. Facility Name (If not institution, gi		ber)				Location of			40	. County of Dea	th	
			Holy Cross Hospi 5. Social Security Number 6.		. Age (In yrs. las	t hirthday)	Silv If Under		pring If Under		9 Date of	Righ	Montgon		s Formian
	Funeral Director		375-28-0426	1X M 2□F	87	Yrs.	Months	Days	Hours	Min.	8. Date of (Month, Apr.	Day Year	917 0	thplace (State o ountry) 1 1 0	r Foreign
			Usual Residence of Decedent							!	F				
	irylan ihow	_	10a. State 10b. County		10c. City, 7	Town or Lo	cation							10d. Inside Ci	
	Ba-f	Director	Maryland Montgor	nery	Silve	er Sp						.,-		M Yes	2 No
	with th	Dir	10e. Street and Number	"			10f. Zip						tizen of What Co	•	
	eath y	era	8201 16th Street	· · · · · · · · · · · · · · · · · · ·	ent Ever in U.S.	12		910	connio Ori	iain? /Sac	oifu Voc or		ted Sta		
'	r Itan	Funeral	1 Never Married 2 Married	Armed Ford	es? 2 □ No 194	1-	If Yes, spec	ify Cubai	n, Mexicar	n, Puerto	cify Yes or Rican, etc.)		Black, Whit		
8	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show lical Esa cher must be notified at	by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	107		1 ☐ Yes 2	No No	Specify:				Specify: African	Americ	an
20	J within 72 hours after death with the Marylan Jiene. r then "natural", or Itams 23a or 28a-1 show The Medical Examinet mant be notified at	Completed	15. Decedent's 8 (Specify only highest g				dent's Usua kind of wor			t of worki	na	16b. K	(ind of Business	/Industry	
121	within ene. then "	ld m	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life.	DO NOT us	e retired,			3	1	T		
5	를 수를 는		17. Father's Name (First, Middle, Las	5+		Prof	essor		18 Mothe	er's Name	(First Mide		Jniversi n Sumame)	ty	
au		o Be	William E. Daver								Kenn		, camamo,		
Maryland 21215-0036	shoul nd Mi marl	2	19a. Informant's Name/Relationship	•		19b. Mailir	ng Address	(Street a					or Town, State,	Zip Code)	
	alth a alth a 27 ls		Ernest Rosemond	(Nephe	w)]	10115	Big :	Rock	Road	i, Si	.lver	Sprin	g, MD	20901	
Ore	of He reference		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	Domoval from St	20b. Plac	e of Dispo	sition (Nam natory or ot	ne of ther place	9)		ate	-1-	ocation - City or	Town, State	
Ĕ	Pag ment ant: I ury o		`4 ☐ Donation 5 ☐ Other (Spec		Ar1i	ingto	n Nat	iona	1	9/2/	04	Ar1	ington,	VA	
Baltimore,	parmit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked eny injury or other traumatic e once.		21. Signature of Funeral Service List	insee (22 M	Name and	d Addres e Fu	s of Facilit neral	l Ser	vice				
	0 D ≥ 0 0		23a. Part1. Enter the disease, or con	yus		7	400 G	eorg	ia Av	ve. N	.W.,		ngton,		0012
			shock, or heart failure. List onl	one cause on ear	ch line.	DO NOT BUT	er the mode	e or crying	, such as	Cardiac o	rrespirator	arrest,		Approximate Interval Bety Onset and D	ween
	Pnysician /Medical		disease or condition resulting in death)	a	el Obsti		on							12 ho	urs
	Examiner				ras a consequer oke – Ac										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	r as a consequer										
	cuted nd ransit	Examine	that initiated events	c											
8760,	cate be axecuted obysician and the burial-transit		resulting in death) Last	Due to (o	r as a consequer	nce of):									
	physic physic the b	dlcal		d											
9 x	certifi ding ise at	Physician/Med	IF FEMALE:	23c. If yes, outco	ome of pregnance	у							23d. Date of de	iven.	
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birt	th 2 Fetal dent at time of deat	eath 3	Ectopic pre Other (spe						Month		'ear
0	that the de led by the detached	hys	9 Unknown	9□ Unknov	vn										
S, P	S E	by P	Part II. Other significant conditions	contributing to dea	th but not resulting	ng in the u	nderlying ca	use give	n in Part I.		23e. Di	d tobacco	use contribute to	the cause of de	eath?
brd	w requires baen sign should be		Renal Failure								1(Yes 2	XONo 3□Pr	obably 4 🔲 U	inknown
Vital Records,	law as b	ompleted									24a. W	itopsy	prior to	itopsy findings a completion of ca	available ause of
E H	ien: The rtificate ha	Cou										rformed? s 2.∑No	death? 1 ☐ Yes	2 🗆 No	
Zi:	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check on				
o		: To	1 ☐ Yes 2 XNo 27. Manner of Death	28a. Date of (Month,		VOutpatier		A Bc. Injury Work	" 4 □ Nu at				6 □Other (Spe	cify)	
o	Attending I r death. actor: After by the funer	atior	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М		? ′es 2.∐.l				,		
Division	or Attendi after death Diractor: A in by the fu	iii	3 ☐ Suicide 6 ☐ Could not determine	28e. Place o	of Injury - At home g, etc. (Specify)	e, farm, str	eet, factory,	, office		2		(Street ar	nd Number or Ru	ural Route Numb	be <i>r</i> ,
Ö	rs after el Dira ed in b	Certification:	- Li Tomolo	Danding	g, etc. (opecity)					1	Ony or	- State	?/ 		
	To the Hospitel or Al within 24 hours after of To the Funarel Dirac completely filled in by	edical	29a. Certifier 1 X Certifying F (Check only one) 1 Medical Exe	hysician: To the b miner: On the bas and manne	is of examination	edge, deatl n and/or in	n occurred a vestigation,	at the tim in my op	e, date an inion, de <i>a</i>	d place, a th occurre	and due to ti ed at the tim	ne cause(s e, date and) and manner as d place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Š	29b. Signature and title of certifie	A	1	1.	29c.	License	number			29d. Da	te signed (Mont	h, Day, Year)	
,	12		Stolm	The	Seel	MI	JI	236	549			Ju1	y 12, 20	004	
			30. Name and address of person who John Stuckey,		of death (lenf 2:			l, Si	Llver	Spr	ing, N	4D 20	0904		
*** £/	Sta Registi	_	31. Date filed (Month, Day, Year) JUL 14 21	32. Dec	gistrar's Signatur		Spa								

			1- For State of Maryland / Dep	partment of Health a	-	giene	23070
	Physici /Medic		Decedent's Name (First, Middle, Last) Mary Lee d'Espard		2. Date of De Month July 1	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of		4c. County of Dea	
			Maple Ridge Assisted Living	Rockville	0411-	Montgo	
	Funeral Director		5. Social Security Number 219-72-2060 Usual Residence of Decedent 6. Sex 1 M 2 X F	y) If Under 1 Year If Under Months Days Hours	Min. (Month, Da	ly, Year) C	rthplace (State or Foreign country) erdale, MD
	Maryland f show	or	10a. State 10b. County 10c. City, Town or t				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28a-	Funeral Director	MD Montgomery Rockvill 10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?
	s 23a	erail	15908 Maple Ridge Court 11. Marital Status 12. Was Decedent Ever in U.S. 13	2085		U.S.A.	- in a finding
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 ie markad other than "naturel", or items 23a or 28a-1 show appropriant: If item 27 ie markad other than "naturel", or items 23a or 28a-1 show appropriately in the Medical Examination must be multified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Zoivorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Orielf Yes, specify Cuban, Mexican Yes 2 No Specify: 		Black, Whi	ite, etc.
21215-0036	within 72 ho	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation ve kind of work done during mosi DO NOT use retired)	t of working	16b. Kind of Business	•
р Б	filed v Hygie ther t		17. Father's Name (First, Middle, Last)		er's Name (First, Middle,	Own Home	2
rylan	hould be d Mental narkad o	To Be	Clarence Owens	1	Marie Kenne	dy	
, Ma	and 2 sl salth an n 27 ie r er traur			iling Address (Street and Number 05 Village Squa			
Baltimore, Maryland	Pages 1 nent of He int: if iten		142 Bunal 2 Cremation 3 Denioval from State	ematory or other place)	Date 7/16/2004	Suitland,	
Balti	permit. Departn Imports any inju		21 Signature of Funeral Service Licensee	22. Name and Address of Facilit Jos 5130 Wisconsin	N/		
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final				Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. Pulmonary Emboli Due to (or as a consequence of):	<u>sm</u>			sudden
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
8760,	icate be executed physician and s the burial-transit	ai Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
687	ficate physics the	edica	d				
P.O. Box	The law requires that the death certific Ite has been signed by the attending p page 2 should be detached for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
S, P.	res that the designed by the	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		obacco use contribute to	
Ö	w require been si should I	eted	Alzheimer's Disease			/es 2 No 3 P	
al Rec		Completed	Hypertension		24a. Was autop perfo 1 Yes		utopsy findings available completion of cause of
ž	siciar	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		of Death (Check only o		cify) Asst. Livin
Division of Vital Records,	ding PI h. After ti funera	tion: To	1 Yes 2 No 10 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time 2 Accident 28c. Time 2 Accident 28c. Time of 28c, Injury at	28d. Describe t	now injury occurred	city) ASSC. LIVII	
Divis	al or Atteness after death i Diractor: d in by the	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (S City or Tox	Street and Number or Ri vn. State)	ural Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director:	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal on the basis of examination and/or is and manner stated.	ith occurred at the time, date and investigation, in my opinion, deat	d place, and due to the th occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number D32332		29d. Date signed (Mont July 12,	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type	a, Print)			
			Suresh Kumar Gupta, M.D. 9801 Geo	rgia Ave. Silve	er Spring,	MD 20902	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Segistrar's Signature	Sparks			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>004</u> **Physician** 3:33 P M George Alan Davis 13, Ju₁y /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 7, 19 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1☐M 2□ F 381-12-9760 Michigan Director 81 1923 Jan. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, If a Madical Examinat must be notified at 1 X Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1329 Chilton Dr. 20904 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes. 2 □ No 1942— If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seco Steel Company District Manager Yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C. Dean Davis Marie Busha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Davis- Wife 1329 Chilton Dr. Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition artment of H sortent: If Its y injury or o 1 N Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 7/19/2004 Silver Spring, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home sendy 11800 New Hampshire Ave. Silver Spring, MD 20904 4 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTIPLE ORGAN **Physician** WEEKS resulting in death) /Medical Due to (or as a consequence of): Examiner WEEKS SEPSIS Socientally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown peed FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed INSUFFICIENCY ULMONARY 1 ☐ Yes 2 X No 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18551 JULY, 13, 2004 M.D. AV. TAKOMA PARK, MD, 20912 ame and address of person who completed cause of death (Item 23a) (Type, Print) NEIMAT, M.D. 7610 CARROLL SAMIR 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

15 2004

Registrar

souls!

			For State	State of Maryla						00071
ĸ	*		1 - State Registrar AMEND ITEM 1. Decedent's Name (First, Middle, Last)	#5 PER FH G	//29/ 9 4	Tillippate of t	2	Reg.		3. Time of Death
	Physici /Medic		Robert James Er	khart Sr.					Day Year 22 2004	6:40a ^M
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
		3 14	Prince George Hosp			Cheverly	I filled - O. Liber		Prince C	
ļ	Funeral Director		5. Social Security Number 6. Sep. 15 219-05-8303	7. Age (In your 9)	Yrs.) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye ct. 12,	ar) 9. Bin Co	thplece (State or Foreign ountry)
	aryland show		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Man a-f sh	ctor	Maryland Prince G	eorge Ca	pitol H	leights				1 A Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	s 23a		5706 Addison Road			20743			ited Stat	
9036	72 hours after death with the Maryland naturel", or Items 23a or 28a-f show Acul Exaculter Casa be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
15-0	72 hours "naturel",	etec	15. Decedent's Edu (Specify only highest grade	cation completed)	(Giv	edent's Usual Occupa a kind of work done	turina most of workina	16b	. Kind of Business	Industry
121	be filed within 72 hatal Hygiene. "natu do other than "natuevent, the Modelland."	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired 1 Miner)	ī	Private	
d 2	illed with I Hygiene. other the	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name (
ılan		To B	George Erkhart				Julia T	Chompson		
, Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type Doris M. Simms/D				and Number or Rural F to1 St. SE			Zip Code) 20019
Baltimore,	2 4 4 5		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, cre rt Linc	osition (Name of ematory or other place oln	May 29	, 2004 B	Location - City or rentwood	
Balt	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service License	Mike	s of Facility Pope 5538 Fore	Funeral Marlbor stville,	Homes o Pike MD. 20	747		
П			23a. Part1, Enter the disease, or compli shock, or heart failure. List only or	cations that caused the de se cause on each line.	eath. Do not er	iter the mode of dying	g, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Cardia	DN1	Mona	ry an	201		Onset and Death
	/Medical Examiner		1 Cooking in dozin,	Due to (or as a cons	equence of):	a Ac	· /			•
		Jer	Sequentially list conditions, it any, leading to infringulate cause. Enter Underlying	joue to (or se a none	equerina of):	, ,				
	cuted nd ransit	Examiner	that initiated events	Prom	MA	4				3 Days
, 0	ificate be executed g physician and as the burial-transit	EX	resulting in death) Last	Due to (or as a cons	equence of):	•				
68760,	physic the b	edical								
_	TO CO	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pred	gnancy				23d. Date of del	verv
.O. Box	0 0 0	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fi 4 ☐ Pregnant at time o 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
rds, P	The law requires that the te has been signed by the has been signed by the age 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not i	esulting in the	underlying cause give	on in Part I.			the cause of death?
of Vital Records,		Completed						24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of 2 No
Vita	Physicien: 1 this certificat ral director, p	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death			
of	Phys r this ral dir	. To	1 Yes 2 100	28a. Date of Injury	ER/Outpatie		4 Li Nursing Home	5 Residence		cify)
O	Attending I r death. ector: After by the funer	Certification:	Natural 5 Pending 2 Accident investigation	(Month, Day Year,	Injury	Work	? Yes 2□No	. Describe now in	ilary occurred	
Division	or Attend after death Director: / in by the f	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - Al		reet, factory, office	281		and Number or Ru	ral Route Number,
Ö	ital or A	Cert	4 Tromode	building, etc. (Spe	icity)			City or Town, St	410)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my ker: On the basis of examinand manner stated.	nowledge, dea ination and/or ii	th occurred at the time exestigation, in my op	e, date and place, and pinion, death occurred	d due to the cause at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
)	To the within To the comple	×	29b. Signature and title of certifier	· Mes	F	D 2	7366		Date signed (Mont)	D. Day, Year)
C	(5)		30. Name and address of person who co	MEHTA	MD	7100 B	altimo	re Ae	Colle	3 20760
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 7 2004	2. Registrar's Sig	nature for	li			_	

DHMH 17 Rev 1/2001

			1 - For State of Maryl Recistrar		artment of H			ene	2227
Par-	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last)	willer		Location of Death	2. Date of Death	6 1 6 6	3. Time of Death
. 4	Examir	er	Shady Grove Adventist Hosp	ital	Rockv		'	Montgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Oay, July 24	Year) 9. Birth	nplace (State or Foreign
	Director		Usual Residence of Decedent	68 Yrs.			July 24	, 1935 Was	shington, DC
Maryla	f shov	lor		: City, Town or Lo fontgome:	ocation ry Village	2			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
d d	r 28e	Irect	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
th wit	23a cast L	raiD	9900 Tambay Court		20886			USA	
d 21215-0036 filed within 72 hours after death with the Maryland	of Mental Hygiene. marked other then "neture!", or items 23a or 28e-1 show matic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 12. Was Decedent Ever Amed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
5-0036	netur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired	ation furing most of work	ing 1	6b. Kind of Business/l	ndustry
121 121	then the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired) Legal Seci			Self Emplo	ved
מ ק	other	Be Co	17. Father's Name (First, Middle, Last)				e (First, Middle, M.		, yeu
arylar	Mental Hygie karked other t	To B	Morrison Lee Sanford			Margare	t Stanto	n	
رة 1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		19a. Informant's Name/Relationship (Type, Print) Mitchel Emswiller – Son					City or Town, State, Z VA 22657	
	f Healt item 2 other		20a. Method of Disposition 20	b. Place of Dispo	osition (Name of			Oc. Location - City or	
altimore,	der Eine		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	Omps Cre	matory`or other place ematory		5 - 04	Winchester	, VA
Balt	Department of Important: If i any injury or one		21. Signatur of Funeral Service Licensee	V .		ın Street	Woodst		2664
L.			23a. Part1 Enter the disease, or complications that caused the c shock or heart failure. List only one cause on each line.	death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	nysician Medical	L	In mediate/Cause (Final disease of condition resulting in death)		1325			2	IMMENIATE
	xaminer		Due to (or as a con	,	FU ISE	187 0	ISEAS.		VE
7	i is	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
y	al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a con	isequence of):					
8760,	physician and is the burial-transit	dicai E	d						
x 68	ling ph	Med	IF FEMALE:						-
Records, P.O. Box 61 The law requires that the death certific	ned by the attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	very Day Year
S, To	igned b	by Pr	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause give	n in Part I.	23e. Did toba	icco use contribute to	the cause of death?
	been sig should b		CHRONE OBSTENIANE	LUNG	DISTA	16	1 🗌 Yes	2 □ No 3 🗹 Pro	bably 4 Unknown
Division of Vital Records,	has be	Completed	HYPERLIPINEMIA				24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
			25. Was case referred to medical			26 Place of Doot	1 🗷 Yes 2	□ No 1 1 2 Yes	2 No
f VI	is cert direct	To Be	examiner?	2 ER/Outpatier	nt 3 DOA Othe		n <i>(Check only one)</i> me 5 ☐ Residen	ce 6 □Other (Spec	ify)
0 0	h. After th funeral		27. Manney of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Yea	28b. Time o	f 28c. Injury Work	at ?	28d. Describe how		
isio	death ctor: / y the f	Certification;	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - A	At home farm st		′es 2 □ No	28f Location (Stre	et and Number or Rui	rai Route Number
	s after I Dire od in b	Serti	4 Homicide determined 288. Place of Injuly 17 building, etc. (Sp				City or Town,	State)	
hs Hospit	within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my 2. Medical Examiner: On the basis of examiner and manner stated.	knowledge, deat nination and/or in	h occurred at the time vestigation, in my op	e, date and place, inion, death occuri	and due to the cau red at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
Ţ.	Tol	Σ	29b. Signature and title of certifier		29c. License	number 5 1 4 3 9		Date signed (Month)	
Ó	25		30. Name and address of person who completed cause of death ((Item 22a) (Tuz-				V	
(2			30. Name and address of person who completed cause of death ($\mathcal{L} = \mathcal{L} = \mathcal{L} = \mathcal{L}$			dical Cen	ter Dr. 1	Rockville,	MD
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's S JUL 13 2004	ignature 🚙	Sporks	/			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			State of Mary	•	rtment of t							
		1. Decedent's Name (First, Middle, Last	2. Date of Dea		04 2	3. Time of Death						
	Physician	Berniece E. Edwar	ds				July 3,	Day 2004	Year	11:06 AM		
1	/Medical > Examiner	4a Fecility Neme (If not institution, give			: 1:	4b. City, Town, or		4c. County		11.00 1111		
		Suburban Hospital				Betheso	la		Montgor	mery		
	Funeral	5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days					e (State or Foreign		
	Director	5/8-13-8328	^{3 M 2}	Yrs.		110010	April 1	4, 191	3 Tole	do, OH		
	Pu s	Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town or Loc	ation				10d	Inside City Limits		
	sho dat				ation				100.	1 ☐ Yes 2 ☒ No		
	the N	MD Montgome 10e. Street end Number	ry]	Bethesda_	10f. Zip Code			0g. Citizen of	Minet Country			
	ritems 23s or 28s-f show inser must be notified at Funeral Director	6530 Democracy Blv	d.		20817			U.S		r		
	items items included	11. Marital Status	12. Was Decedent Eve Armed Forces?	rin U,S. 13. W	as Decedent of I Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		ce - American			
21215-0020	by	1 ☐ Never Married 2 ☐ Merried 3 🔯 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗓 No If Yes, Give Yeer or Detes:		□Yes 2Ñ No				y: White			
2-0	ed within 72 hours ygiene. ier than "naturel", it, the Medical Ext Completed by	15. Decedent's Edu (Specify only highest grad	cation	16a. Decede	ent's Usual Occup	pation	rkina	16b. Kind of B	usiness/Indus	try		
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7	A Street	12			Homema				Home			
ī	tal H d oth	17. Father's Neme (First, Middle, Last)					me (First, Middle, I		ne)			
3	Men Men Men Men Men Men Men Men Men Men	Alfred W. Reiser		1			Ly Schnei					
Ma	alth and 2 St le n 27 le n pr treur	19a. Informant's Name/Relationship (T) Patrick J. Vaughan				d Center		-				
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: if item 27 ie merked other than "natur eny injury or other treumatic event, the Medical ange. To Be Completed	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □F	Annual from Chats	20b. Place of Dispos cemetery, crem. Gate of He	atory or other pla	nce)		20c. Location	-			
Ħ	artmen ortant: Injury	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		22	Name and Addre	ass of Facility	Jul 20043 · s					
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		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the	death. Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory arm	est,	Ap	proximate terval Between		
L	Physician /Medical	Immediate Cause (Final		_					Or	nset and Death		
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	icate be executed physicien end s the burial-transit edical Examiner	Sequentially list conditions	<u>Urosepsi</u>	S to (or as a consequ	ence of):							
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	- 006 -	resulting in death) Lest	Tougoaut	ogia					i			
Вох	at the death cert d by the ettendin letached for use Physician/M		<u>Leucocyt</u>	0515								
_•	e des he et ned fc	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the unc	derlying cause giv	ven in Part I.	23b. Did to	bacco use co	ntribute to th	e cause of death?		
P.0	v requires that the death cert been signed by the ettendin should be detached for use leted by Physician/M	Anemia					1 □ Y	s 2 No	3 Probab	ty 4X Unknown		
ds	signed Id be d						24a. Wes a	n autonsv	24b. Were	autopsy findings		
()	The law requir sate has been si page 2 should						perform	ned?	availal compl	ble prior to etion of cause		
Re	The law ate has the page 2 s						and the same	s ZLNo	of dea			
ā	or. pa	25. Was case referred to medical				OC Diana of Day	ath (Check only on		1 1	es 2 No		
5	hysicia his cert il direct To B	eyaminer?	lospital: 🏡 Inpatient	2 ☐ ER/Outpatient	3□ DOA Ott	hor	ome 5 ☐ Reside	-	er (Specify)			
9	erthis eral d	27. Menner of Death	28a. Date of Injury (Month, Day Ye		28c. tnju		28d. Describe ho		1-127			
Ö	Attending or death. ector: After by the fune iffication	1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 16	ar) Injury		Yes 2 □ No						
Division of Vital	tal or Attending P rs after death. al Director: After t led in by the funer? Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - building, etc. (S	At home, farm, stre	et, factory, office		28f. Location (St City or Town		er or Rural Ro	oute Number,		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: Medical Certification: To Be Compl		ician: To the best of m									
	ithin 24 on the F omplete	one)	and menner stated.	ra sedica a facilità de	29c. Licens					```		
	Tiv Co	29b. Signature and title of certifier	Voh	no M.	D-202		2	9d. Date signe July	3, 200	-		
	10	30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, P	rint) Bethesda	. MD 2081						
		Kirti Vohra, M.D. 7710 Bradley Blvd. Bethesda, MD 20817 31. Dete filed (Month, Dey, Year) 32 Registrer's Signature										

DHMH 16 Rev 6/95

			For State Registrar		State of N		id / Depa		t of H	ealth a		_		21101.	23877
			1. Decedent's Name (Fir	st, Middle, Lasi)							2. Date of D Month	eath Da	ıy Year	3. Time of Death
	Physici /Medio		ANNA	В	•		ETE	KIND						2004	20:25 M
سوي ز	Examir		4a. Facility Name (If not	institution, give	street and number	ir)		4b. City,	Town, or	Location o	of Death			. County of Dea	
			SHADY GROVI	E ADVEN'	TIST HOS	PITAL			ROO	CKVIL	LE			MON	TGOMERY
	Funeral		5. Social Security Number		x 7.7		last birthday)	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Bi	irth av. Year	9. Bii	rthplace (State or Foreign ountry)
	Director		060-24-8883		1M 2LAF	90	Yrs.					01/01/	1914	NEW	YÓRK
	pug *		Usual Residence of Dec 10a. State 10b	edent c. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits
	sho	៦		-											1 X Yes 2 □ No
	he N	Director	MARYLAND MO	ONTGOME:	RY	ROCE	VILLE	101 7:-	0-4-				40- 0		
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	ter d	Ę	1 Never Married	2□ Married	Armed Force	s?		f Yes, spec	offy Cuba	n, Mexican	, Puerto	ecify Yes or N Rican, etc.)		Black, Whi	
39	urs af	by	3 ⊠Widowed 4 □		If Yes, Give Year or Dates		-	1 ☐ Yes	2 🛚 No	Specify:				Specify:	WHITE
ð	2 hou	ted	15.	Decedent's Edu	ıcation		16a. Dece	dent's Usua	al Occupa	ition			16b. K	(ind of Business	s/Industry
75	within 7 ene. than "n	pie	(Specify or Elementary/Secondary	nly highest grad	College (1-4c	r 5+)	life.	kind of wor DO NOT us	rk done d se retired)	luring most)	of work	ing	HTG	H SCHOO	Τ.
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פ	be filed within 72 ho ital Hygiene. id other than "natui event, Ire Modical	BeC	17. Father's Name (First	, Middle, Last)						18. Mothe	r's Name	First, Middle	, Maider	Sumame)	
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Maryland 21215-0036	s 1 and 2 should Health and Meritem 27 la marke other traumatic		19a. Informant's Name/I				19b. Mailir	ng Address	(Street a	n <i>d</i> Nu <i>mb</i> e	r or Rura	al Route Numb	oer, City	or Town, State,	Zip Code) 20878
	1 and 2 Health tem 27 I		BARBARA ETK	IND/DAU	GHTER		14226	FLOE	RAL I	PARK 1	DRIV	E, NOR	TH P	OTOMAC,	MARYĨĂŇĎ
Baltimore,	of Head		20a. Method of Dispositi		Damental frame Char		Place of Dispo	sition (Nan	ne of ther place	e)	TIIT	Y 12,	20c. L	ocation - City or	Town, State
Ĕ	it. Pages I rtment of H rtant: If ite njury or ot		1½ Burial 2 ☐ Cri 14 ☐ Donation 5 ☐			te	ANKLIN	-				04	ELM	IRA, NE	W YORK
aĦ	C 40 0 0		21. Signature of Funera	l Service Licens	See	,	22	Name an	d Addres	s of Facility	Y NTED A	T DIDE			
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			23a. Part1. Enter the dis shock, or heart fail	sease, or comp	lications that caus	ed the deat									Approximate Interval Between
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9	death certifica e attending ph id for use as tl	Med	IF FEMALE:												
Вох	ath cr ttend or us	lan/	23b. Was decedent pred in the past 12 mon	gnam	23c. If yes, outco <i>n</i> 1∐Live birth	2 Feta	Ideath 3	Ectopic pre						23d. Date of de Month	livery Day Year
o.	the deay the a	Physician/M	1 ☐ Yes 2 🔯 No 9 ☐ Unknown		4□Pregnant 9□Unknown		eath 5∟	Other (sp	ecity)	-				Wiena	buy rour
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ec	2 2	npie										24a. Was	psy	prior to	utopsy findings available completion of cause of
	Th ate pag	Completed										1 Tes	or <i>m</i> ed? 2 ⊠ No	death?	2 □ No
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of	this aldi	2	1⊠Yes 2□No		Hospital: 1 ☐ Inpa		ER/Outpatien			4 Nui				6 □Other (Spe	ecify)
Ē		on:	27. Manner of Death 1 ⊠Natural 5 [Pending	28a. Date of Ir (Month, L	ijury Da <i>y Year)</i>	28b. Time of Injury		8c. Injury Work			28d. Describe	how inju	ry occurred	
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\leq	al or Attend after death Director; d in by the f	rtifi	4 ☐ Homicide	determined	28e. Place of I building,	njury - At he etc. <i>(Specif</i>	ome, far <i>m</i> , str y)	eet, factory	, office		1	28f. Location (City or To	Street ar wn, State	nd Number or Ri e)	ural Route Number,
	urs al														
	Hospital	edicai	(Check only 2	Certifying Phy Medical Exam	sician: To the besiner: On the basis	of examina	wledge, death ition and/or in	n occurred a restigation,	at the ti <i>m</i> , in my op	e, date and inion, deat	d place, a h occurr	and due to the ed at the time,	date and) and manner as d place, and due	s stated. e to the cause(s)
	the the	Med	one) 29b. Signature and title	of certifier	and manner	stated.		200	. License	number			29d Da	te signed (Mont	th Day Year)
	or Vale	_	LSD. Signature and title) \(\)	120	a.	, ~>	-4			7			7 11, 20	
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١	9		30. Name and address of) 10.0	ידזעט	7 77	MADVI	MID	20050	
	-01		DR. JONATHA 31. Date filed (Month, Di		E, 9901 1	trar's Signa	. 20				, كالما	MAKYLA	TND	20850	
	Sta Registr			16 201		ممعنه	B	ppo	uls						

			For State Registrar	State of M	laryland		artment o			Mental Hy	giene		23270
П	9		Decedent's Name (First, Middle, I	Last)		***				2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Maria Victo		norado					Ju1y	6 20	004	11:00 A ^M
7	Examin	er	4a. Facility Name (If not institution, g			n+0**	4b. City, To	wn, or Loca ville		ath	4c. County	of Death	
			Shady Grove Adve	. Sex 7. A	ige (In yrs. lasi		If Under 1 Y		nder 24 H	rs. 8. Date of Birt			e (State or Foreign
	Funeral Director		578-56-0989	1□M 2 ∑ F	89	Yrs.	Months D	ays Ho	urs Mi	n. 8. Date of Birt (Month, Date Dec 2	y, Year) 3 1914	Country, Cuba) (J. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation					104	Inside City Limits
	Aaryla f shov	ō	Maryland Montgo	merv		hers						100.	1 ☐ Yes 2X No
	the A	rect	10e. Street and Number		Juli	-IICIS	10f. Zip Co	ode			10g. Citizen of V	What Country	?
	h with	ai D	18807 Pintail L	ane			208	379			Cuba		
	ems ?	Funerai Director	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.	Was Decedent	t of Hispani Cuban, Me	ic Origin?	(Specify Yes or No- erto Rican, etc.)	- 14. Rac	e - American ck, White, etc.	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	Armed Forces d 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates		- 1	Yes 2			Cuban	Specify		
8	thour stures	ed b	15. Decedent's			16a. Dece	dent's Usual C	ccupation			16b. Kind of Bu		
2	hin 72 3. an "na Medi	Completed	(Specify only highest : Elementary/Secondary (0-12)	grade completed) College (1-4or	r 5+)	(Give life.	kind of work o DO NOT use r	fone during retired)	most of w	vorking			
7	ed wii	Con	8			House	wife			(5)	Own Hor		
and	be fit ad oth	Be	17. Father's Name (First, Middle, La Medin Trinchet							ame (First, Middle,	Maiden Suman	ne)	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel', or Items 23a or 28e-f show eumatic event, the Medical Examiner must be notified at	은	19a. Informant's Name/Relationship			19b. Mailir	ng Address (S			a Ruiz Rural Route Numbe	er, City or Town,	State, Zip Co	nde)
ĭ	nd 2 s alth ar 27 Is r treu		Juan Anselmo Ena	morado / S	100					Gaithersb			
ore,	ss 1 a of Hez	ñ	20a. Method of Disposition 1 □ Burial 2 🌣 Cremation 3	Domewal from State		e of Dispo	sition (Name on atory or other	of r place)	Т.,	Date 1y 8,	20c. Location -	City or Town	, State
<u>Ĕ</u>	Page ment of uny or		`4 □Donation / □ Other (Spe	ecify)			tan Cr		ry 2	004	A1exandı		irginia
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		21. Signatule Funeral Service Lie	ensee						DeVol Fun			0077
	40260		23a. Part1. Enter the disease, or co	omplications that caus	ed the death.					r. Gaith			J8 / / oproximate
	Dhamisian	e d	shock, or heart failure. List or Immediate Cause (Final	nly one cause on each	line.			, ,		,,,		In	terval Between nset and Death
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r)	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Chapter of hijury		is a consequer	nce of):							
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8760,	death certificate be executed e attending physician and nd for use as the burial-transit	calE		d									
9	tificate ig phy as the	ed .											
Вох	eath certific attending p for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	ne of pregnancy 2 □Fetal de		∃Ectopic pregr	nancy			23d. Dai	te of delivery nth Da	y Year
о. П	at the dea by the at tached fo	/sici	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of deat	h 5[Other (special	fy)				nur Da	y real
<u>α</u>	The law requires that the tee has been signed by the bage 2 should be detache	/ Ph	Part II. Other significant condition	s contributing to death	but not resulting	ng in the u	nderlying caus	se given in F	Part I.	23e. Did to	obacco use conti	ribute to the c	ause of death?
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CO	aw requin as been si 2 should I	olete								24a. Was	an 24b. \	Were autopsy	findings available
		Completed								autop perfor	rmed?	death?	etion of cause of
Vital	Physicien: The I rthis certificate ha ral director, page	Be	25. Was case referred to medical examiner?					0.4		eath (Check only o	ne)		
of \	를 글 등	2	1 ☐ Yes 2X No 27. Manner of Death	1	tient 2 ER	VOutpatier 3b. Time o			Nursing	Home 5 Resid	dence 6 Other		
0	ding h. After funer	tion	1X Natural 5 Pending 2 Accident investiga	28a. Date of In (Month, E	Day Year)	Injury	M .	Injury at Work? 1 Yes	2 🗆 No	Zod. Describe r	low injury occurr	90	
Division	Attending r death. ector: After by the fune	ifica	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of I		ə, farm, str	eet, factory, o	ffice		28f. Location (S City or Tow	Street and Numb	er or Rural Ro	oute Number,
ā	tel or rs afte et Dir	Certification:			etc. (Specify)								
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the bes xaminer: On the basis and manner:	of examination	edge, deatl a and/or in	h occurred at t vestigation, in	he time, da my opinion	ite and pla i, death oc	ce, and due to the courred at the time, of	cause(s) and ma date and place, a	inner as state and due to the	d. e cause(s)
	To the To the Comp	×	29b. Signature and title of certifier		/		29c. L	icense num	ber		29d. Date signed		
	2			ALL	\sim			400	51:	584	3-5	5-90	100
			30. Name and address of person Anushiravan Dad		,		,	ark T	'erra	ce Germa	ntown. N	MD 208.	74
	Sta	ite	31. Date filed (Month, Day, Year)	32, Regis	strar's Signatur					JOIIIG		200	
	Registr		JUL 12 20	JU4 500	mar /	S	Spork	2					

				State of	Marylar		artment e <i>rtificate</i>			Mental Hy	giene Reg. No.2	n L	23879
			1. Decedent's Name (First, Middle, La	st)						2. Date of De	ath	V	3. Time of Death
	Physici /Medio		Delphine Keles	ke Favi	11a					July	12 2	Year 004	2:30am
)	Examir		4a. Facility Name (If not institution, giv	e street and numb	oer)			4	b. City, Town, or	Location of Deat			
			12117 Drews Cour						Potom		Mont	gomei	СУ
	Funeral	1	5. Social Security Number 6. S	ex 7. □M 252 F	Age (In yrs.	last birthday Yrs.	/) If Under 1 Months		If Under 24 Hrs Hours Min	. (Month, De	th y, Year)	9. Birthp	place (State or Foreign
	Director		393-26-3847 Usual Residence of Decedent		74	115.				Mar 17	1930	Wisc	consin
	end **		10a. State 10b. County		10c. Cit	y, Town or I	_ocation					1	0d. Inside City Limits
	Mary	ট	MD Montgom	ery	I	otoma	.c						1 ☐ Yes 2∰ No
	1 the	<u>1</u>	10e. Street and Number				10f. Zip (Code			10g. Citizen of V	What Cour	ntry?
	3a o	0	12117 Drews Court				2	0854	4		USA		
	within 72 hours after death with the Marylend ene. then "netural", or items 23a or 28e-f show he Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decede		,S. 13	. Was Decede	ent of H	ispanic Origin? (In, Mexican, Pue	Specify Yes or No	- 14. Rac	e - Americ	
0	or ite		1 ☐ Never Married 2 ☐ Married		955 – 19	262	1 Yes 2		Specify:	to Alcan, etc./			
9	ural',	d by	3⊠ Widowed 4 □ Divorced	Year or Date	es: JJ I.							White	
5	"net	Completed	15. Decedent's Ed (Specify only highest gra			(Giv	edent's Usual re <i>kind</i> of work DO NOT use	k done d	during most of wo	orking	16b. Kind of B	usiness/In	dustry
Maryland 21215-0020	withir ene.	Ĕ	Elementary/Secondary (0-12)	College (1-4 4	or 5+)				″ ľherapis	+	Distric	t of	Columbia
0	e filed within al Hygiene. I other than '		17. Father's Name (First, Middle, Last,	•		UCCu	pation	laı .		me (First, Middle			COTUMBIA
<u>a</u>	should be nd Mental marked o	To Be	Stanley Keleske						Verd	nica Mo	r		
ar _Z	should and Men marke umartic		19a. Informant's Name/Relationship (Type, Print)						ural Route Numb			Code)
Σ	s 1 end 2 should be filed within 72 hours aft feelth end Mental Hygiene. tem 27 is marked other than "netural", or other traumatic event, the Medical Example.		Teresa Favilla -	daughter		281	5 Ball	iet:	t Court,	Vienna,	VA 221	80	
Baltimore,	permit. Pages 1 end 2 Department of Heelth e Important: If Item 27 is any Injury or other tree		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Damarral from Ct		lace of Disp semetery, cr	oosition (Namematory or oth	e of her plac	e)	Date	20c. Location -	City or To	wn, State
Ĕ	Par in a go		4 □ Donation 5 □ Other (Specif			erly C	remato	ry		7/15/04	Alexan	dria,	, VA
at	aparti aporta iy Inj		21. Signature Funeral Service Licer	see /] /	n	20	22. Name and	d Addres	ss of Facility E	verly Wh	eat1ey	Funer	al Home
Ш	40 E 2 9		1/4 Seit C.	(list	11.	360	1500 W	lest	Braddoc	k Rd. Al	.exandri	a, VA	A. 22302
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the deat	h. Do not e	nter the mode	of dyin	g, such as cerdia	c or respiratory a	rrest,		Approximate Interval Between
1	Physician											j	Onset and Death
/	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Endo	metrii	lal C	ancer					13	years
		16	resulting in death)		Due to (d	or as a conse	equence of):						-
	nsit	Examiner		b			, ,					İ	
Ċ,	eath certificete be executed attending physician and for use as the burial-trensit	Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying		Due to (c	or as a conse	equence ot):					!	
68760,	se be sicia e bur	edicai	that initiated events	c	Due to (o	r as a conse	equence of):						
_	tificel gphy as th		resulting in death) Last				1-0					į	
Box	death certi e attending ed for use a	Physician/M		d					<u>, </u>			1	
	o o	Sici	Part II. Other significant conditions of	ontributing to deat	th but not res	ulting in the	underlying ca	use give	en in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
o.	that the de led by the a detached f	F								1□	Yea 2□ No	3 ☐ Prol	oably 4 ☐ Unknown
	Se Pe Se	5										0.41 141	6-1
of Vital Records,	v require been si should	Completed									an autopsy rmed?	ava	ere autopsy findings ailable prior to mpletion of cause
န္တ	aw 2 s	jdu										of	death?
<u> </u>	Page 1									-40%	Yes X No	10	Yes 92 No
<u> </u>	Physician: The this certificate oral director, pag	8 B	25. Was case referred to medical examiner?	Hospital:				Othe	OF:	ath (Check only o			
ō	φ ω Ω	-1 10	1 ☐ Yes 2 ☐ MNo 27. Manner of Death	1 ☐ Inp	patient 2□ Injury	ER/Outpatie 28b. Time			4 Li Nuising	Home 5 Resi	dence 6 □Oth now injury occuri		y)
	ding h. After fune	뎚	1X Natural 5 ☐ Pending	(Month,	Day Year)	Injury	м м	Bc. Injury Work 1 □ `	k? Yes 2 □ No	Zou. Dosonibo	low injury occur	ou .	
Division	Attending or death. ector: After by the fune	fica	3 Suicide 6 Could not b	e 28e. Place of			treet, factory,	office			Street and Numb	er or Rura	I Route Number,
á	of or a setter or bire	Certification:	4 ☐ Homicide		, etc. <i>(Specit</i>		,			City or To	vn, State)		
	e Hospital or Attend 124 hours efter death 9 Funeral Director: /		29a. Certifier 1 XCertifying Ph										
	To the Mospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edicai	(Check only 2 Medical Examone)	niner: On the basi and manne	s of examina r stated.	tion and/or i	nvestigation, i	in my of	oinion, death occ	urred at the time,	date and place, a	and due to	tne cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier	1 -		¢.,	29c.	License	e number		29d. Date signe	d (Month,	Day, Year)
	allo		()	Ck lo	20 205	-	P	54	798		7.14	04	
	10		30. Name and address of person who	V									
			Cheryl A. Ayleswo			0 Rocl	kledge	Dr.	Bethes	da, MD	20817		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Reg	jistrar's Signa	ature /4	Lon	· Ka					

DHMH 16 Rev 6/95

		State of Maryland / De	partment of Health and Me	•	•
		_ FOI	ertificate of Death		2004 23880
Phys	sician	1. Decedent's Name <i>(First, Middle, Last)</i> Gladys Wittcke Gaucher	2		Day Year 3. Time of Death 2210 PM
	edical miner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		3 2004 Z210 FM tc. County of Death
		THE MEMORIAL HOSPITAL	EASTON		TAIBOT
Funer Direct		5. Social Security Number 051−18−1548 6. Sex 1	Months Days Hours Min.	Date of Birth (Month, Day, Yea Sept. 24,	9. Birthplace (State or Foreign Country) 1923 New York
yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
4 Within 72 hours after death with the Maryland liene. Then "naturel; or Items 23e or 28e-f show then the Rammer wat be notified a	ctor	Maryland Talbot Eas			1) Yes 2 □ No
with th	Directo	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
Jeath ms 23	Funeral	7384 Brett Road 11. Marital Status 12. Was Decedent Ever in U.S. 1	21601 3. Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No-	USA 14. Race - American Indian,
after or Ite	Fur	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☒No Specify:	can, etc.)	Black, White, etc. Specify:
bours ture!,	od by	3 Wildowed 4 Divorced Year or Dates:	cedent's Usual Occupation	15h	White Kind of Business/Industry
IZI 3-UU36 ithin 72 hours aft ne. hen *naturel*, or Medical Exam	plete	(Specify only highest grade completed) (Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working DO NOT use retired)	7	Kild of business/fidustry
0 00 0	Completed	12 8	Homemaker		Own Home
Tal Be	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maide Burkhard	· ·
Maryia d 2 should th and Men 7 Is marks treumetic	ှင		ailing Address (Street and Number or Rural		
- c = N L		Diane Gaucher Aberg/Daughter 294	71 Nancy Street, Eas	ton, MD	21601
Te it is		I Dunai 2 Meniation 3 Deninovarion State I	sposition (Name of Dairrematory or other place)	1/2	Location - City or Town, State
Baltimo permit. Page Department of Important: If any Injury or		'4 □Donation 5 □ Other (Specify) MidShore 21. Signature of Funeral S. reign Licensee	eCremationCenter 7/1		Cambride, Maryland
Depert	ouce	CHEROLATING OF THEM LIXON	Curran-Bromwell Fundament High St., Cambr	eral Home	P.A. 21613
		23a. Part 1. Enter the disease, or complications that caused the death. Do not sheek, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
Physicia		Immediate Cause (Final disease or condition Ashuatton	,		Onset and Death
/Medic Examin		Due to for as a consequence of):	1 disease		40000
	Je Je	Sequentially list conditions, if any, leading to numericale cause. Enter Underlying Cause (Disease or injury)	1 constant		16005
ecuted and transit	Examiner	that initiated events			
fou, te be executed ysician and e burial-transit	7	5 5 6 (5) table 5 (6) table 5 (6) (6) table 5 (6) (6) (6) (6)			
DO/ ifficate g phys as the	edic	d			
Hecords, P.O. BOX 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
he dear the air	Vsici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Month Day Teat
COTGS, P.O. w requires that the de been signed by the s should be detached	Y Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ords equire en sig	ted b	Congestive heart fulline		1 🗆 Yes	2 No 3 Probably 4 Winknown
fecord law requir has been si e 2 should la	npie	Khennetoid disease		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	e Cor	25. Was case referred to medical		performed?	death?
ystcien: is certific director,	To Be	examiner? 1 Yes 2 500 Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (tient 3 DOA Other: 4 Nursing Home		6 □Other (Specify)
n or ng Phy fter this	on: T		e of 28c. Injury at 28	d. Describe how in	
DIVISION OT VITA or Attending Physicien: after death. Director: After this certific in by the funeral director,	catl	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	M 1 Yes 2 No	f Location (Street	and Number or Rural Route Number,
_ = = .= c	Certification:	4 Homicide determined building, etc. (Specify)	street, factory, office	City or Town, Sta	ite)
LIVISION OT To the Hospitel or Attending Phys within 24 hours after death. To the Furnerel Director: After this completely filled in by the funeral di	Medical C		eath occurred at the time, date and place, an r investigation, in my opinion, death occurred	d due to the cause I at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To the within To the comple	Me		29c. License number	_	Date signed (Month, Day, Year)
		▶ labhmi Vardyanathan M	D DO5-774	9 Ni	1414 2004
		30. Name and address of person who completed cause of death (Item 23a) (Type Lakshmi Vaidyanathan, M.D., 219 S.		Factor *	4D 21601
	State	31. Date filed (Month, Day, Year) 1 5 200 42. Register's Signature	Mashington Street,	maston, P	ID STOOT
	istrar	JUL I 3 LUPT Steller St	upour		

GAUCHER, GIADYS

Registrar

12

Baltimore, Maryland 21215-0036

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68760

Box

Division of Vital Records, P.O.

31. Date filed (Month, Day, Year) JUL 16 2004



c (a our

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAMIN OSKOVI, M.D., 3301 NEW MEXICO AVENUE, NW WASHINGTON, DC 20016

D40576

July 13, 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
ROBERT 2. Date of Death GALKIN HERBERT **Physician** YIUL 10, 2004 2:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. 6. Sex 8. Date of Birth

Month, Day, Year)

JAN. 17, 1936 **Funeral** 9. Birthplace (State or Foreign Months **X**☐M 2□ F Days Hours Min 214-32-8898 68 NEW YORK Yrs. Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show treumatic avent, the Medical Examiner must be notified at Director XXYes 2 □ No MARYLAND MONTGOMERY POTOMAC 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8011 GRAND TETON ST. 20854 UNITED STATES OF AMERICA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status o filed within 72 hours after de la Hygiene. □Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygient Importent: If item 27 Is marked other the eny injury or other treumatic avent. Intelliging once. ENTREPRENEUR TELECOMMUNICATIONS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DAVID GALKIN ROSE NACHT 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA S. GALKIN - WIFE 8011 GRAND TETON ST. POTOMAC, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 X Removal from State KING DAVID MEMORIAL GARD. 07/13/04 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral S EDWARD SAGEL FUNERAL DIRECTION, INC 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC BRONCHOGENIC CARCINOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe PNEUMONIA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No 24a. Was an certificate has 2**K** No 1 ☐ Yes Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Anpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce D26571 JULY 10, 2004 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who IRVING MIZUS, MD 10215 FERNWOOD ROAD, # 401, BETHESDA, MD 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 16 2004 Registra

			1 ← For Stete Registrar	State of	Marylan	d / Depa		of H	lealth a		•		0001	·.	200	20
		_	Decedent's Name (First, Middle	, Last)			timodic				2. Date of I	Death	7 7 7 1 6	1	3. Time of I	Death
	Physici		William Michae	1 Galvin.	Jr.						July	8,	2004 Y	er	9:00	РМ
	/Medio Examir		4a. Fecility Name (If not institution,				4b. City,	Fown, or	Location o			Ť	4c. County of [Death	7.00	
	LAGIIII		11657 Asbury Ci	rclé :			Solo	mon	s				Calvert	:		
	Funeral			6. Sex 7	. Age (In yrs. I	ast birthday)	If Under Months		If Under 2	24 Hrs. Min.	8. Date of 8				ce (State or	Foreign
	Director		579-30-3319	1 ∑ M 2□F	76	Yrs.	WOTHING	Days	Hours	WILL.	8. Date of 8 (Month, 1) Feb.	9, 1	1928 Wa	shing	ton, D	.C.
	pug A		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							100	d. Inside Cit	e Limita
	laryla sho	ō					Joans							100	1 Yes	
	28a-i	ect	Maryland Calve:	rt	Sol	omons	10f. Zip	Code		-		100	Citizen of Wha	. Counts		
	with Ba or		11657 Asbury Ci	ralo Por F	: = 0		206									
	ns 2%	era	11. Marital Status	12. Was Deced		S. 13.1			ispanic Orio	gin? (Spe	ecify Yes or I		ited St			
ري وي	or Iten	by Funeral Director	1 Never Married 2 Marrie	Armed Ford	2 ☐ No		_			, Puèrto	ecify Yes or f Rican, etc.)			Vhite, et		
ĕ	ral', c	by	3	If Yes, Give Year or Dat	es: WWII		1 ☐ Yes 2	! X . No	Specify:				Specity:	Whit	ce	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent' (Specify only highes	s Education t grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	Occupa	ation during most	t of worki	na	16b	. Kind of Busin		stry	
12	vithin ne. hen.	ig.	Elementary/Secondary (0-12)	College (1-	4or 5+)							_	Natio			
7	lled v lygie her t	S	17. Father's Name (First, Middle, L	5+		Elec	trica	1 Er			(Firm & Adiata		oadcastin den Sumame)	g Cor	mpany	
and	ntal Hed ol	Be	William Micha											. 1		
2	should ad Me mark matic	은	19a. Informant's Name/Relationsh			19h Mailir	na Address	(Street s					Shepher ty or Town, Sta		ode)	
<u>8</u>	nd 2 s lith ar 27 ls r treu		Laurie Galvin/										ls, Mar			3/4
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then. Importent: If Item 27 is marked other then an inatural; or Items 23a or 28a-f show any injury opether treumatic event. The Medical Examiner qual be notified at once.		20a. Method of Disposition		20b. P	lace of Dieno	eition /Nam	o of	1		te 17,		Location - City			J4
Ë	Page High		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		late Nat	ional	ingto	n	6) T	_	04	Ar	lington	. Vi	roini	а
a ====================================	mit. partm porte y inju		21. Signature of Funeral Service L		12.00	22	. Name and	Addres	s of Facility	y Ro	bert A	. Pı	umphrey	Fun	eral H	lome/
m	8 9 1 1 8		Day In	2	M014	05 Be	thesd	la-Cl	hevy (Chas,	208 Inc	7.	557 Wis	cons	sin Ave	enue
			23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that car	used the death									A	oproximate	
	Physician		Immediate Cause (Final disease or condition		and Nec	k Sous	mons	Ce1	1 Can	cer				C	onset and Do Mont	eath
	/Medical Examiner		resulting in death)		r as a consequ		inoub	001	ı odır.	CCI					110116	110
	Lxammer	_	Sequentially list conditions,	b												
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause End Underlying Cause (Disease or injury	Due to (o	r as a consequ	Jence ot):								4		
	xecul and al-trar	xan	that initiated events resulting in death) Last	c Due to (o	r as a consequ	ience of):								-		
09/1	death certificate be executed e attending physician and id for use as the burial-transit	icai E	Į.	d												
9	tificat g phy as the	edic														
Box	eath certific attending p for use as i	M/uı	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnath 2 Petel		Ectopic pre						23d. Date of	delivery		
	a deat he att ed for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of de		Other (spe						Month	Da	ay Ye	ear
o.	at the de I by the a stached	Phys	9 🗆 Unknown								-11					
Ś	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition	ns contributing to dea	ith but not resu	ılting in the uı	nderlying ca	use give	en in Part I.				o use contribut			
ecords,	requi	ted					_				1 X	Yes	2 □ No 3 □	Probab	Ur	iknown
ec	e 2 sl	Completed										opsy	prior	to comp	y findings av	vailable use of
E E	t: The lavicate has										1 Tyes	formed 2X		n? Yes 2[□No	
Vital	ysicien: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only		-			
ō	Phys r this ral di	-: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 ☐ Ing 28a. Date of		ER/Outpatien 28b. Time of		Bc. Injury	4 LI NUI				6 Other (5	Specify)		
0	ding F th. : After : funera	tion	1 X Natural 5 ☐ Pending investig:	(Month,	Day Year)	Injury	M	Work	:? ′es 2 □ N			3 110 11	nary occurred			
DIVISION	or Attending Physicien: ifter death. Director: After this certification by the funeral director.	ifica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place o	f Injury - At ho	me, farm, str	eet, factory,						and Number of	r Rural R	Route Numbe	er,
5	a afte	Certification:	4 Homicide	building	g, etc. (Specify	")					City or T	own, St	ate)			
	ospit hours unere ly fille		29a. Certifier 17 Certifying	Physician: To the b examiner: On the bas	est of my know	wledge, death	occurred a	t the tim	e, date and	d place, a	and due to th	e cause	(s) and manne	r as state	∍d.	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	Ulley	and manne	r stated.					.n occurre	ed at the time					
	con Con	~	29b. Signature and tille of certifier	1 d 12	-				number				Date signed (M		y, Year)	
1	5+1		Ley 1	Kyly	1100	7		5437	78			Ju	1y 9, 2	004		
,	1		30. Name and address of perston v	. (1			,	.a r	Jos+	#/.00	T.TL	+	M 1	an 1	20002	
	* Sta	te	Cheryl A. Aylest 31. Date filed (Month, Day, Year)	32. Rec	gistrar's Signat					#400	, wnea	LON	, maryl	and .	20902	
	Registr	•	JUL 12	2004	epera	Ø	Spo	uks								

			1 - For State Registrar	State of	Marylar		artment of rtificate o			lental Hy	/gien	1001	238	84
	Physici		1. Decedent's Name (First, Midd Margaret Dean							2. Date of De	eath	004 Ye		of Death
	/Medio Examir		4a. Facility Name (If not institution 4925 Battery		nber)		4b. City, Towr Beth	n, or Location	n of Death		-	c. County of D	eath gomery	
	Funeral Director		5. Social Security Number 074-30-7551 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 86	last birthday) Yrs.	If Under 1 Ye Months Day		er 24 Hrs. Min.	8. Date of Bi (Month, Di Septer		9.3 917 Ho	Birthplace (State Country) pkinsvil	or Foreign
	e Maryland a-f show	ctor	MD 10b. County MD Montg		10c. Ci	ity, Town or Lo Bethe							10d. Inside (City Limits
	th with th	Funeral Director	10e. Street and Number 4925 Battery L	ane #701			10f. Zip Code 20817					itizen of What	Country?	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 ia marked other than "natural", or items 23a or 28a-f show any injury ocother traumatic event, the Medical Examination is indiffed at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 🏋 Widowed 4 ☐ Divorced	If Yes, Give	ces? 2 [X] No e		Was Decedent of If Yes, specify C	uban, Mexic	an, Puerto	ecify Yes or No Rican, etc.)	0-		merican Indian, hite, etc. White	
Baltimore, Maryland 21215-0036	ed within 72 h giene. er than "natu r. the Medical	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	nt's Education est grade completed)	4or 5+)	16a. Deced (Give life. Homer	dent's Usual Occ kind of work do DO NOT use ret naker	cupation ne during ma ired)	ost of worki	ing		Cind of Busine		
yland	ould be file Mental Hy harked oth	To Be (17. Father's Name (First, Middle, Charles Carric	k Crain					Lois	Elise l	East	land		
e, Mar	1 and 2 sh Health and em 27 la m Iher traum		19a. Informant's Name/Relations Margaret Kauf 20a. Method of Disposition			3006	Harvard		MAdis		537	05		
Itimor	it. Pages intment of i reant: If its njury of o		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (5) 21. Signature of Funeral Service	Specify)		ck Cre	ek Cem	olace)	July	14 2004		hingto	or Town, State	
Ba	perm Depe impo		23a. Part1. Enter the disease, o	2	wood the deep	5		consin	Jos Ave.			's Son	spc Inc	
	Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. <u>Meta</u>	ich line.	Lung		ying, such a	as cardiac o	respiratory a	irest,		Approxima Interval Be Onset and Years	tween
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S	or as a consec									
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		rth 2 ☐ Feta ant at time of c	al death 3	Ectopic pregnar Other (specify)					23d. Date of o	,	Year
	w requires that been signed b should be deta	by	Part II. Other significant conditi Atheroscles		ath but not res	sulting in the ur	nderlying cause	given in Pari	t I,		obacco Yes 2	_	to the cause of	
Il Records,		Completed	Peripheral	Vascular I)isease	2				24a. Was autor perfo		prior t	autopsy findings to completion of c ? es 2 \(\square\) No	available cause of
Division of Vital	To the Hospital or Attending Phyaician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	Hospital: 1 ☐ In 28a. Date of (Month)		ER/Outpatien 28b. Time of Injury	28c. In	Other: 4 🗆 N	lursing Hon	(Check only one Since Page 1) Resident (Check only of the control	dence		pecify)	
Divis	spital or Attendi ours after death. teral Director: A filled in by the t	Certification:	3 Suicide 6 Could 4 Homicide determ	ingd 286. Place	of Injury - At hi g, etc. <i>(Specil</i>	ome, farm, stre	eet, factory, offic	8	2	28f. Location (S City or Tox			Rural Route Nurr	nber,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one)	ng Physician: To the b Examiner: On the ba and manne	sis of examina	wledge, death ation and/or inv	estigation, in my	opinion, de	and place, a eath occurre	ed at the time,	date and	d place, and d	ue to the cause(s	s)
,	1>	<	29b. Signature and title of certifie	Ubiot	nt	7	D31	319				te signed (Mo 1y 9, 2	nth, Day, Year) 2004	
			30. Name and address of person Loretto Albiol 31. Date filed (Month Cay Year)	M.D. 821	8 Wisc	onsin A	ve. Bet		, MD :	20814				
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2004	gistrar's Signa	9	Span	2						

			For State Registrar	State of	Maryland	-	artment of Hertificate of L		Mental Hy	rgiene Reg. No. 11 11	23005
	Physici		1. Decedent's Name (First, Middle, Gladys Geisle						2. Date of De Month July	100	3. Time of Death 11:15 A M
	/Medio Examin		4a. Fecility Name (If not institution, Manor Care of		er)		4b. City, Town, or Wheat			4c. County of De	ath
Ī	Funeral Director		5. Social Security Number 214–16–4715		Age (In yrs. la 93	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Da	9. B ay, Year) 7, 1910 Mar	irthplace (State or Foreign Country) yland
	e Maryland 8e-f show	Director	Usuel Residence of Decedent 10a. State 10b. County Maryland			Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	th with th	al Dire	10e. Street and Number 4305 Mainfield	Ave.			10f. Zip Code 21214			10g. Citizen of What (Country?
336	urs after dea al', or Itema Adminar ma	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? [XNo	l:	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2 🏋 No	spanic Origin? n, Mexican, Put Specify:	(Specify Yes or No erto Rican, etc.)	o- 14. Race - An Black, Wh Specify:	nericen Indian, lite, etc. White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28e-1 show among vietry grother treumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give life. L	lent's Usual Occupa kind of work done di DO NOT use retired) Care Provi	uring most of w	rorking	16b. Kind of Busines Childca	12.
Maryland 2	uld be filed v Mental Hygie rked other i tic event, the	To Be Co	6th 17. Father's Name (First, Middle, L Unknown	ast)						, Maiden Surname)	
	and 2 shousaith and N		19a. Informant's Name/Relationsh			4305	Mainfield	d Ave.		er, City or Town, State, e, MD 21214	
Baltimore,	Pages 1 tment of He tant: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	10	ar Hil	sition (Name of natory or other place L1 Cemete:	~v 7/1	Date 4/2004	20c. Location - City of	e MD
Bal	permit Depar Impor any in		21. Signature of Funeral Service I	Wil		11	800 New H	lampshi	re Ave. S		.ng, MD 20904
	Pnysician /Medical		23a. Part . Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a	Seps	is	er the mode of dying	, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death Days
8760,	cate be executed physician and physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence as a c	ary Tr ence of):	act Infec	tion			Days
O. Box 68	The law requires that the death certific. Ite has been signed by the attending pl age 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 ☐ Fetal of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
٦.	w requires that been signed b should be deta	by	Part II. Other significant condition Dehydration		h but not resul	Iting in the ur	iderlying cause give	n in Part I.		obacco use contribute Yes 2 No 3 F	to the cause of death? Probably 4 \textbf{Y}Unknown
Vital Records,		Completed	Atrial_Fibr	illation					24a. Was autor perfo 1 - Yes	prior to death?	utopsy findings available completion of cause of
o	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig.			R/Outpatient 28b. Time of Injury	DOA Other	Nursing		one) dence 6 □Other (Sp how injury occurred	ecity)
Division	Hospital or Attendi La hours after death Funeral Director: A etely filled in by the fi	Certification;	3 Suicide 6 Could n 4 Homicide determin	ned Zoe. Flace U	Injury - At hor , etc. (Specify)		eet, factory, office		28f. Location (S City or Tox	Street and Number or F wn, State)	Bural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier 12 Certifying (Check only one)	Physician: To the be xaminer: On the basi and manner	s of examination	rledge, death on and/or inv	occurred at the time estigation, in my opi	e, date and place nion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	2		Me			29c. License			July 13,	
			30. Name and address of person w	D. 9801 Ge	orgia A	Ave. S		Silver	Spring,	MD 20902	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 15 2	32. Reg	istrar's Signatu	5	Sporks				

			1 - For State Registrar		\$	State	of Mar	yland /		artmer rtificat				/lental		iene •g. No,?	0.0	1.	330	0.0
	Physicia	an	Decedent's Name		e, Last)									2. Date Mont JUL			, Y	'ear	3: Time of I	
	/Medic	al		ERI	LOI			STEI	N	45 63	T				Υ /,				4:00P	M
	Examin	er	4a. Facility Name (If HOLY CRO				imber)			1		Location of SPRIN				MON'	unty of TGON			
	Funeral		5. Social Security Nu		6. Sex	LLI	7. Age ((In yrs. last	birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date	of Birth				ace (State or	Foreign
	Director		216-74-03	28	1 🗆 N	1 2[X F		45	Yrs.	Months	Days	Hours	Min.	DEC.	$^{th}\mathcal{G}_{\bullet}^{ay}$	1958			NGTON,	
	pug 🔉		Usual Residence of I	Decedent 10b. County			1	IOc. City, To	own or Lo	ocation								10	Od. Inside City	. Limita
	Maryli f sho	ō	MARYLAND	MONT		RY				SPRI	NG								1 Yes	
	r 28a-	Director	10e. Street and Num	ber		<u> </u>				10f. Zip	Code				10	0g. Citizer	of Wha	at Count		
	h with	al D	1111 UNI	VERSI	TY BI	JVD.	#123	18			20	902			UN	NITED	STA	ATES	OF AM	ERICA
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other treumetic event, the Medical Evaninar must be notified at once.	y Funeral	11. Marital Status 1 X Never Marrie		ried	If Yes. G	orces? 2[X No ive	er in U.S.	- 1	Was Deceilf Yes, spe		ispanic Ori an, Mexicar Specify:		ecify Yes Rican, et	or No- c.)			America White, e		
Ö	hours turel	q pa	3 Widowed 4	15. Deceder		Year or I	Dates:	1.0	6a Dece	dent's Usua	al Occup	ation				16b. Kind				
7.	in 72 n "na edic	Completed by		y only highe		completed,			(Give	kind of wo DO NOT u	rk done d se retired	during mos f)	t of work	ring		160. Kind	or Buşir	ness/ina	ustry	
212	d with	Com	12	uary (0-12)		College ((1=401 5+)		CLE	RICAL						STUD	ENT	LOA	NS	
nd	be file tal Hy d oth	Be	17. Father's Name (F	irst, Middle,	Last)									e (First, M		Aaiden Su	mame)			
<u>ya</u>	d Men narke	은	HARRY								15			COHE						
Ma	d 2 st th and 17 is n treun		DAVID ULA				IN-L		96. Mailii 251	ng Address 14 CH	(Street a	and Numbe Y HOU	er or Rur ISE (a <i>l Route N</i> COURT	vumber, DE	City or To	US,	MAR	Code) YLAND	2087
ē,	tem 2		20a. Method of Dispo	sition				20b. Place	of Dispo	osition (Nar	ne of	-> [Date	- 2	20c. Locat	ion - Cit	ty or Tov	vn, State	
OE .	Pages nt: If i		1 X Burial 2 ☐			noval from	State	KING :		matory or o D MEM			D. 0	07/12	704	FA	LLS	CHU	RCH, V	A
Baltimore, Maryland 21215-0036	permit. Departm Importa eny inju		21. Signature of Euro	eral Service	Licensee	_				ANZAN 170 R										
П			23a. Part1. Enter the shock or hear	e disease, or failure. List	complica only one	tions that cause on	caused the	ne death. D							-				Approximate Interval Betwe	een
	Pnysician	11	Immediate Cause (F	inal	,	RESP	IRAT	ORY F	AILU	RE									Onset and De	
	/Medical Examiner		resulting in death)					onsequence SPIRA		DICT	DECC	CVMD	ромі	7				5	WEEKS	
		<u>~</u>	Sequentially list con-	ditions,	b			SP. LKA		DIST	KESS	SINL	KOFII	.			_		WELKO	
	uted d ansit	Examiner	if any, leading to im- cause. Enter Underl Cause (Disease or in that initiated events	ying - njury	<		(, , , , , , , , , , , , , , , , , , , ,												
o,	an and rial-tra	Еха	resulting in death) La	ast	C	Due to	(or as a c	consequenc	ce of):											
8760	cate be executed bhysician and the burial-transit	dical			d															
9	ertifica ding ph	Med	IF FEMALE:		00-	16								-						
Вох	death certific e attending p od for use as	Physician/Med	23b. Was decedent in the past 12 n	nonths?	230	1 Live	birth 2	pregnancy □Fetal dea ne of death		Ectopic pr						23d.	Date o Month	f deliver	y Day Ye	ar
o.	0 0 0	ysic	1 ☐ Yes 2 X ☐ 9 ☐ Unknown	No		9□ Unkr		ne or death	51.	Other (sp	өспу)				_					
σ,	requires that the leen signed by th hould be detache	by Pr	Part II. Other signific	ant conditi	ons contri	buting to d	leath but i	not resulting	g in the u	nderlying c	ause give	en in Part I.		23e.	Did tob	acco use	contribu	ite to the	cause of dea	ath?
rds	w require been sig should b	ed b	ESOPHA	GEAL C	ANCE	R									1 🗌 Ye	s 2□N	0 3[Proba	bly 4 □Un	known
Vital Records,	law as b 2 s	Completed													Was an autopsy		4b. Wer	e autop:	sy findings av	ailable
<u> </u>	The ate h page	Con													perform		deal	th?	2□ No	136 01
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referre examiner?			يحى: spital:					Othe			h Check						
	hys this at di	- To	1 ☐ Yes 2 ☐X	lo		1 12	Inpatient of Injury		Outpatier	nt 3□ DC	A Injury	or: 4 □ Nu		me 5 🗌 28d. Desc				Specify)		
on	Attending r death. ector: After by the fune	tlon	1 Xiatural 2 Accident	5 Pendir investi	.9	28a. Date (Mor	ith, Day Y	'ear)	Injury	M	8c. Injury Work 1 🗆 \	(?ົ` ∕es 2 🗆 !		Lou. Desc	1100 110	··· Injury oc	Currou			
Division of	or Attending Paffer death. Director: After in by the funera	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could determ		28e. Place	of Injury	- At home,	farm, str	eet, factory	, office		Ī	28f. Locat	ion (Str	eet and N	umber c	or Rural	Route Numbe	er,
	0 = 5 = 1	Cert	- Indiniciae			build	ling, etc. (эрөспу)						City	г Томп,	Jiaie)				
	호수 교육	Medical	29a. Certifier (Check only one)	Certifyin	ng Physic Examine	r:On the	e best of r asis of ex iner state	kamination	dge, death and/or in	h occurred vestigation	at the tim , in my op	e, date and pinion, deal	d place, th occurr	and due to red at the t	the ca time, da	use(s) and te and pla	manne ce, and	er as sta due to t	ted. he cause(s)	
	To the within 2. To the complete	Σ	29b. Signature and ti	tle of certifie	(1/			M	290	. License	number			29	d. Date si	gned (N	Aonth, D.	ay, Year)	
)	15		170	MY	50	U	ler	_/	10	ソ	2	20562				JULY	7,	200)4	
			30. Name and address BARRY J.	1 2 /				th (Item 23a			CAO	STL	VER	SPRTN	IG.	MD 2	090	1		
	Sta	te	31. Date filed (Month				Registrar's	s Signature						~ I I I I						
	Registr		JU	13	2004	13	new		9	1,00	K									

			1 - For State Registrar		State of	Marylan		artmen rtificate			and N		Reg. No.2	004	23887
н	Physici	an	Decedent's Name (First, Middle	, Last)								2. Date of Dea Month	Day	Yeer	3. Time of Death
	/Medio	al	CARRIE 4a. Facility Name (If not institution		abel	205	40	OVER		Lasation	of Dooth	07	11	2004	7. 20 7 M
1	Examir	ier	GOI MA ALA GAR	, give s		yer)		46. City,	TOWIL, OF	Location of	or Death	ND	40.000	or Death	11
	Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs.	last birthday)	If Under		If Under		8. Date of Birt (Month, Day	h	9. Birthr	place (State or Foreign
	Director		219-74-2787	1 🗆	M 20 F	9	Yrs.	Months	Days	Hours	Min.		y, Yeer) /// ///2.	NA COU	yland
	2		Usual Residence of Decedent			1.0.00				-		1	1		
	show	-	10a. State 10b. County			10c. Cit	y, Town or Lo	ocation						1	1 ☐ Yes 2 No
	the Maryla 28a-f shor	ecto	Maryland Garre	tt_			Grants								
	£ 9 €	Funerai Director			-			10f. Zip						of What Cour	ntry?
	eath w	erai	851 Maple Grove		1 d 2. Was Deced	ent Ever in II	S 13		1536	snanic Ori	nin2 (Sn	ecify Yes or No.	USA	Race - Americ	can Indian
		ä	1 ☐ Never Married 2 ☐ Marr	_ 1	Armed Forc	es?				n, Mexicar	, Puerto	ecify Yes or No- Rican, etc.)	E	Black, White,	
036	hours after turel', or Ite al Examina	by	3 ☑ Widowed 4 ☐ Divorced		If Yes, Give Year or Date			1 ☐ Yes 2	No 🎎	Specify:			Spe		ite
21215-0036	72 hours "naturel"	Completed	15. Deceden (Specify only higher	's Educ	ation		16a. Dece	dent's Usua	l Occupa	ation	t of work	ina	16b. Kind o	f Business/In	
2	를 등 등 최	npie	Elementary/Secondary (0-12)	, grade	College (1-4	for 5+)		kind of wor DO NDT us	e retired)	i or work	9		- 2000	
	be filed wit tal Hygien d other the	ပ္ပ	7	1			Home	maker	1	40.44.0	T. N.	(FT		Home	
Ē		Be	17. Father's Name (First, Middle,	Last)						18. Mothe	ers Nam	e (First, Middle,	Maiden Sun	name)	
Z	should be nd Menta marked imatic ev	²	George Washingt				105 14-11	4 44	(C4===4)			lare) al Route Numbe	- 02T	- Cara 7:-	0.7-1
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relations Beatrice Folk	וויט (ייאָג	1 0 , Filit)										
	s 1 an if Heali item 2 other	1 8	20a. Method of Disposition			20b. P	lace of Dispo	sition (Nan	ne of	-		Grantsv <u>i</u> Date		on - City or To	536 own, State
2	00		1 ☐ Burial 2 XCremation 4 ☐ Donation 5 ☐ Other (S		emoval from St	ate	emetery, cre.				uly	12,		- 12.00	
Baltimore,	mit. Pag bartment bortent; I r injury o		21. Signature of Fureral Service.		e	Cou	ntry S	2. Name an			v	2004		sville.	
Ba	permit. Departn Importe any inju		1 () Ly ~ (no	oma	w/	N	ewman	Fun	eral	Home	s, P.A.			Street MD 21536
8760,	/Medical /Medical Examiner	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or	r as a consequal r as a consequal r as a consequal r	uence of): uence of):	g. On			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7			Mon Tas
P.O. Box 68	t the death certifica by the attending ph ached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23		n 2 ☐ Feta nt at time of d	death 3	□Ectopic pro □ Other (sp						Date of delive Month	ery Day Year
	quires tha n signed l	þ	Part II. Dther significant condition	ons con	tributing to dea	th but not res	ulting in the u	inderlying ca	ause give	on in Part I.		23e. Did to			ne cause of death?
Division of Vital Records,	e = e	Completed										24a. Was a autop perfor	sy	prior to con death?	psy findings available mpletion of cause of 2 No
ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medica examiner?	-						26. Place	of Deat	(Check only o			
<u>></u>	Q 5.	ို	1 Yes 2 No	Н	ospital: 1 🗆 Inp		ER/Outpatie			4 □ Nu	rsing Ho			Other (Specifi	y)
Ē			27. Manner of Death 1 △Natural 5 □ Pendir		28a. Date of (Month,	Day Yeer)	28b. Time o Injury		8c. Injury Work			28d. Describe h	ow injury occ	curred	
Sio		cat	2 Accident investi 3 Suicide 6 Could	-	On a Planta	Alabara Akha	6	M		Yes 2.□.	No .	OOK Laastias /G			10-1-11
Ξ	or At after of Direct in by	Certification:	4 Homicide determ	ined		f Injury - At ho g, etc. <i>(Specif</i>		reet, ractory	, office			City or Tow	n, State)	mber or Hura	I Route Number,
_	Hospitel 14 hours (Funerel I	edicai Ce	29a. Certifier (Check only one) Certifyir	g Phys Exemin	icien: To the b er: On the bas and manne	is of examina	wledge, deat tion and/or in	h occurred avestigation,	at the tim in my or	e, date an pinion, dea	d place, th occur	and due to the c	cause(s) and date and place	manner as si	ated. the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifie	r				290	. License	number			29d. Date sig	ned (Month,	Day, Year)
•	⊨ s ⊨ ō) Para	00	0-	0			1+2	615	-4		7/	17	104
			30. Name and address of person	who co	mpleted cause	of death (Item	1 23a) (Type,			- / (/				, _	/ /
			P. Daniel N	1/2	v DU	694	2016	Acr	25	Dri	عد	Ochka	ud,	MDZ	555
	Sta Regist		31. Date filed (Month, Day Year)	13	2004 Reg	gisfrar's Signa	ture	Lan	W				,		

		•	1 - For State Registrer	State of Maryla		artment of F			jiene	23888
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat		3. Time of Death
	Physicia		Genevieve	Virginia		Hahn		Month July	Day Yeer 9. 2004	12.55 A M
	/Medic Examin		4a. Facility Name (If not institution, giv				r Location of Dea		4c. County of Dea	
			Cuppett Weeks No	irsing Home			0akland	l	Ga	rrett
	Funeral	2	5. Social Security Number 6. S	ex 7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth		rthplace (State or Foreign country)
	Director		218-16-3456	□M 2対F 83	Yrs.			May 11,	1921 Ma	ryland
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	sho	5			.,,					1 ☐ Yes 2 ☑ No
	he N	ect	MD Ga:	rett		0aklan	ıd		0g. Citizen of What C	
	with a or	ᡖ					01550	-		,
	eath	by Funeral Director	14625 Garrett H:	Lgnway 12. Was Decedent Ever in	U.S. 13		21550	Specify Yes or No-		SA lencan Indian
	ter d	Š	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		f Yes, specify Cuba	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, Wh	
336	urs al	ğ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2☑ No	Specify:		Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show ha Medical Examiner must be nutitled at	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	advia a	16b. Kind of Busines	s/Industry
215	hin 7	pje	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	d) most of we	rking		
21	giene giene grant grant	Š	6th			Housewif	e		H	ome
덜	al Hy I oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, I	Maiden Sumame)	
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Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than " freumatic event, the Mes		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or A	ural Route Number	r, City or Town, State,	Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at		Cheryl Shaffer/c				Road, Oa	kland, Me		
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Itam 27 is any injury or other trau		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, crea	sition (Name of natory or other place	ce)	Date	20c. Location - City o	r Town, State
Ĕ	Pages ment of I ant: If Its ury or o		`4 □ Donation 5 □ Other (Special		akland	Cemetery	7/1	2/04	Oakland, M	aryland
alt	permit. Departr Importa any injl		21. Signature of Funeral Service Lice	1000		2. Name and Addre	A THE REAL PROPERTY.		Funeral Ho	
	897 2 29		Loden	1-Notes	3	32 S. Sec	ond St.,	Oakland,	, Ma. 2155	0
			23a. Pert1. Enter the disease, or the shock, or heart failure. List only	plications that caused the de- one cause on each line.	ath. Do not en	er the mode of dyin	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Dementia						Onset and Death Months
	/Medical		resulting in death)	Due to (or as a conse	equence of):					
	Examiner		Sequentially list conditions,	b. Alzheimer		ase				Years
	of sit	Examiner	Sequentially list conditions, if any, leeding to immediate Cause (Disease or injury	Due to (or as a conse	equence of):					
	death certificate be executed e attending physician and nd for use as the burial-transit	кап	that initiated events resulting in death) Last	c Due to (or as a conse	equence of):					
8760,	be ex	in in		200 10 (01 20 20 00 100	.440.100 0.71					
87	cate physi the	dicai		_ d				-		
9 ×	ding	/Me	IF FEMALE:	23c. If yes, outcome of preg	nancy				23d. Date of de	Ni non
Box	atten for us	ian	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tel death 3[Ectopic pregnancy Other (specify)	1		Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	36	J Citter (specify)				
Δ.	requires that the des een signed by the a hould be detached f	by Physician/Me	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	bacco use contribute t	to the cause of death?
ds,	98	d b						1 □ Y€	es 28€No 3∏P	robably 4 Unknown
of Vital Records,	> 11 (A	Completed						24a. Wasa	n 24h Wara a	utopsy findings available
Rec	2 25 2	m du						autops	sy prior to med? death?	completion of cause of
a	ılcian: Th certificate rector, paç		25. Was case referred to medical							s 2□No
₹		o Be	examiner? 1 \(\sum \) Yes \(\sum \) No	Hospital: 1 ☐ Inpatient 2[☐ ER/Outpatier	nt 3 DOA Oth	6.7	ath (Check only on	ence 6 Other (Spe	
of	Phys r this sral di	1: 10	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ow injury occurred	ecny)
on	ding th. Afte	tior	Natural 5 Pending 2 Accident investigation		Injury		k? Yes 2 ⊡No			
Division	Atten dea octor	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injury - At	home, farm, st	eet, factory, office			reet and Number or F	lural Route Number,
Š	after after Dire	erti	4 Homicide	building, etc. (Spec	city)			City or Town	n, State)	
	spits nours nara		29a. Certifier Certifying Pl	nysicien: To the best of my kr	nowledge, deat	h occurred at the tir	ne, date and plac	e, and due to the ca	ause(s) and manner a	s stated.
	To the Hospital or Attending Phys within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral di	Medicai	(Check only 2 Medical Exe	miner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, death occ	urred at the time, da	ate and place, and du	e to the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Mon	th. Day, Year)
			• /			1	H26154		7-10	-04
			30. Name and address of person who	completed octse of death (Ite	em 23a) (Type,		1140134			,
		3	P. Daniel Miller	D. O. 69 W	olf Acr	es Drive	. Oakaln	d, Md. 21	550	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrat Sign		Amil?	0	,		
	010			1 3 2004	con Ass	pater.	C .			

		State Registrar		Ce	rtificate of	Death	-	Reg. No.	104	23889
Physicia /Medica	in al		Horsman				2. Date of De Month	Day	Year 2004	3. Time of Death 9:00 A
Examine	er		land Medica		Ball	or Location of Dec	ity		inty of Death	
Funeral Director		218-24-4361	CM OFF				Jan. 1	7, 1929	Cour	place (State or Fore ntry) Land
Ba-f ehow	ctor	10a. State 10b. County Maryland Dorchest							1	10d. Inside City Lin 1 X Yes 2 □
3a or 28	Social Security Number 6. Sex 1 cm 20 7. Age (th yrs. has beinday) flunder Year H Index (24 hrs. 10. Base of Birm 20 10. Base		ntry?							
al', or Itams 23a or 28a-f ehow Exterili er mast be notified at	by Funera	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of If Yes, specify Cui	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or No irto Rican, etc.))- 14. F	Black, White,	
Department of Health and Mental Hygiene. Important: If item 27 Ie markad other than "natural", any injury or other traumatic event, tr.e. Micals. Exi	mpleted	(Specify only highest gra	ade completed)	(Give	kind of work done DO NOT use retire	during most of world)	orking			
ental Hygie kad other t ic event, IL	Be	17. Father's Name (First, Middle, Last,		Pro	oof Reade	18. Mother's Na				
and Me le mari aumati	F			19b. Maili	ng Address (Stree			er, City or Tov	wn, State, Zip	Code)
of Health Fitem 27 r other tr		20a. Method of Disposition		20b. Place of Dispo	sition /Name of					wn, State
partment portant: It injury o	1	' 4 □ Donation 5 □ Other (Specif	4	Crematory	of Delma	arva 7/1		Delmar	, Dela	ware
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		Part II. Other significant conditions c	ontributing to death but	not resulting in the u	nderlying cause gi	ven in Part I.				e cause of death?
has je 2	Сошріе						autop	med?	prior to con death?	esy findings availa apletion of cause
reci reci	ם	examiner?	Hospital:		Ott					
fter this	- 1	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day)	28b. Time of	28c. Injui	y at rk?)
To the Funeral Director: A completely filled in by the fu	Sillica		28e. Place of Injury building, etc.	- At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow	itreet and Nun n. State)	nber or Rural	Route Number,
To the Funer completely fill		2 modical Exam	miler. On the basis of ex	kamination and/or inv	occurred at the til restigation, in my o	me, date and place opinion, death occi	e, and due to the curred at the time, o	ause(s) and n date and place	nanner as sta e, and due to	ited. the cause(s)
Tot	Σ .	29b. Signature and title of certifier Bult 13	A MD			_	2			
	1	_ , , , , ,			1 10	- 01				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Robert C. Huss 7-12-04 4:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7400 Cliff Borne Ct. Derwood Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1⊠M 2□F Yrs. Director 273-14-5804 83 9-7-20 Ohio Usual Residence of Decedent the Maryland 10a, State 10c, City, Town or Location 10b County 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at Director 1 Yes 2 No MD Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or items 23e 7400 Cliff Borne Ct. 20855 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WW I If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 21X Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No p Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene important: if item 27 is marked other then "ns any injury or other treumetic event, If a Misally once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Specialist Dept. of Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred E. Huss BEssie Thelka Lewis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1200 N. Nash St. #820 Arlington, VA 22209 19a. Informant's Name/Relationship (Type, Print) Jerri H. Rush - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Cemetery 7-14-04 Quantico, VA 22. Name and Address of Facility Hines-Rinaldi F. H. 21. Signature of Funeral Service Licensee 200 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic bladder cancer months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. physician Physiclan/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tyes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 2X No 1 ☐ Yes 2 ☐ No 1 Yes Hospitei or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check on one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 🛣 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М after death Director: / 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hour. the Funerel Direc-4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel within 2 To the 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) D0033793 7-13-04

State Registrar

16 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Smith M. D.

5454 Wisconsin Ave. Chevy Chase, MD 20815 oaks

P.O.

			For 1 State	State of M				t of H	ealth a	and M	-	/giene	220	
	Physici		1. Decedent's Name (First, Middle	, Last)		H3U	inoatt	01 2			2. Date of D	Reg. No.	200°4	3. Firme of Dealth M
	/Medic Examin		4a. Facility Name (If not institution HOLY CRUSS	HOSPITAL			SILV	in	SPRI	NG		N	County of Dea	MtRy
	Funeral Director		5. Social Security Number 070-52-6407 Usual Residence of Decedent	6. Sex 7. Ag 1 □ M 2 💢 F	59	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, D MARCH	8, 194	5 TA	nthplace (State or Foreign ountry) IWAN
	Maryland e-f show	ctor	10a. State 10b. County MD MONTG	OMERY	10c. Cit	y, Town or Lo S	cation ILVER	SPR	RING					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the 23a or 28	Funeral Director	10e. Street and Number 3005 S. LEISU					20	906				usa of What C	
920	s within 72 hours after death with the Maryland liene. I than "neturel", or Items 23a or 28e-f show than Madical Examinat must be notified at the Madical Examination.	þ	11. Marital Status 1 □ Never Married 2 ☒ Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Deced If Yes, spec 1 Yes 2		ispanic Ori n, Mexicar Specify:		cify Yes or N Rican, etc.)		4. Race - Am Black, Wh Specify:	
21215-0036	within 72 ho ene. than "netur ne Madical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12		5+)	16a. Dece (Give life. REGIS	kind of wor DO NOT us	rk done d se retired	during mos ()	t of workii	ng		d of Business	
Maryland 2	be filed ital Hyg id othe event,	To Be Co	17. Father's Name (First, Middle, CHI—FAN	Last)	KIANG	L					(First, Middl	e, Maiden		ING
	s 1 and 2 should I Health and Men item 27 ie marke other treumatic		19a. Informant's Name/Relations ZUTZANG HSU 20a. Method of Disposition	HUSBAND	20b. F		S. L	EISU	JRE WO	ORLD		SILVI	Town, State, ER SPR cation - City o	ING, MD 20906
Baltimore,	ermit. Pages epartment of upportent: If i ny injury or nce.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) 21. Signature of the all Service	pecify)		LINCO	OLN CI 2. Name an	REMA' d Addres	TORY	ty 118	OO NEV	V HAMI	SHIRE	MARYLAND AVE. /ER SPRING,MD
	Pnysician /Medical Examiner	ner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as	d the deat ne. a consequence								, O - 31L	Approximate Interval Between Onset and Death
8760,	tate be executed obysician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. MUCTI Due to (or as	OPG a conseq OTIC	Uence of):	STEN MBO	ofte	ATLU Pali	RE IC P	URAV	R4		2 WKS
.O. Box 68	The law requires that the death certificat tite has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	ıl death 3□	Ectopic pr Other (sp					2	3d. Date of de Month	elivery Day Year
<u>a</u>	w requires that is been signed by should be deta	by	Part II. Other significant condition	ALURE, DE					A .	UTUS				o the cause of death?
Vital Records,		Completed	HEPATATIS								per 1 ☐ Yes	opsy formed? 2 \Begin{align*} No	24b. Were a prior to death?	utopsy findings available completion of cause of
Division of Vit	Hospitel or Attending Physicien: T 4 hours after death. Funerel Director: After this certificat tely filled in by the funeral director, ps	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investig 2 Accident 6 Could determ	gation not be 390 Place of In	iry iy Year) jury - At h	28b. Time o Injury	f 2	8c. Injury Work 1 🔲 `	er: 4 □ Nu	ursing Hor	28d. Describe	idence 6 how injury		ecify) tural Route Number,
_	To the Hospitel or within 24 hours affer To the Funerel Dir completely filled in	Medical Co	29a. Certifier 1 Certifyin (Check only one) Medical	g Physician: To the best Examiner: On the basis of and manner st	of my kno of examina ated.	owledge, deat ation and/or in	h occurred vestigation,	at the tim	ne, date an pinion, dea	nd place, a th occurre	and due to the	e cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
	To the Z	M	29b. Signature and title of certifie	Cus -	MD			036	252			JUL	4 12,2	th, Day, Year)
			30. Name and address of person STEVEN T, KAK 31. Date filed (Month, Day, Year)	who completed cause of CINAL MD, 1/5	death (Iter	turge,	A A	E 8	TE S	75, u	i HOAT	DN Y	10 20	1962
	Sta Regist		31. Date filed (Month, Day, Year)	2004 32. Begist	اها s Signa	G	Spo	rils	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2027 Lucille JWARN 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE 8. Date of Birth (Month, Day, Year)

Nov. 23 1918 Washington D.C If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Hours **Funeral** 1 □ M 2 🗷 F 579 09 3039 85 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthen "neturel", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Montgomery Gaithersburg Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 United States 1014 Quince Orchard Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Administrator County Government permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Importent: If item 27 is marked other th
eny Injury or other treumatic event, III
once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ninoth McCracken Harry Nussbaum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald E. Howard / Son 19830 Bucklodge Road, Boyds, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/04 Parklawn Cemetery Rockville, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Muriel H. Barber Funeral Home murel Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Obstructive HRUNIC **Physician** eav > /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Physician/Medical the as use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 X Yes 2 No 3 Probably 4 Unknown CARDIUMYUNATH Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Maberes autopsy performed? 1ty outensing
25. Was case referred to medical examiner? page 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Daath Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, for u signed by the a peen has le 2 certificate this After thi To the Funeral Director: completely filled in by the

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

4 - Homicide

1 🖒 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

11 x 27 A Jyoc

29c. License number D 53317 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16220 frederick Rixo S-. to 213 Gaithurburg Jugah Ball 31. Date filed (Month, Day, Year)

State Registrar

16 2004 32. Registrar's Signature

within 24 hours a To the Funerel I

Medical

			1 For State Registrar	State	of Maryland	d / Depa		t of He	ealth ar	nd Menta		e	1. 23902
Y	Physic /Medi Exami	cal	1. Decedent's Name (First, Midde 4a. Facility Name (If not institution Prince Geor	n, give street and no	umber)	var	4b. City,	Town, or l	ocation of C	J Mon	4	7, 20 c. County of	3. time of Death 3. 00 M 1 Death e George's
	Funeral Director	Destruction	5. Social Security Number 052-44-9067 Usual Residence of Decedent	6. Sex 1⊠M 2□F	7. Age (In yrs. Ia		If Under Months		If Under 24		of Birth th Day Yea 15/19		9. Birthplace (State or Foreign Country) Brooklyn, N.
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show alcal Exertiner must be notified at	Director	10a. State 10b. County	ce Georg	e's La	, Town or Lo	er 10f. Zip	Code 0785			1	itizen of Wh	10d. Inside City Limits 1 ☐ Yes 2 🚰 No nat Country?
5-0036	n 72 hours after death with the Marylar "natural", or Items 23a or 28a-f show edical Exertirer must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	12. Was Dec Armed F ned 1 1 2 Yes If Yes, G Year or 0	cedent Ever in U.Sorces?	9	Was Deced f Yes, spec	ent of His fy Cuban No	panic Origin Mexican, P	? (Specify Yes uerto Rican, et		14. Race -	American Indian, White, etc. Black
2121	c • 3	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12) 17. Father's Name (First, Middle,		(1-4or 5+)		tent's Usual kind of won DO NOT us h Pro	k done du e retired) ofes	ring most of		Un	iver	-
Maryland	should be filed within and Mental Hygiene. I marked other than armatic event, the Mental Mental armatic event, the Mental armatic event, the Mental armatic event, the Mental armatic event.	To Be	Evans Heywa 19a. Informant's Name/Relations	rd		19b. Mailir	a Address		Mae (Name (First, A Chisol or Rural Route I	m		
Baltimore, Ma	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumatic event, If a Mones.		Pearl Heywa 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (\$200) 21. Signature of Funeral Service	rd/Wife 3 ©Removal from		2368 ace of Dispo metery, cren	Veri sition (Nam natory or oti Nat	mont he of her place)	Ave	.#301 Date 14/04	Lando 20c. L Bea	ver, I ocation - Ci aufor	MD 2-785 ity or Town, State t, S.C. VICE, P.A. ring, Md20910
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heaf failure. List Immediate Cause (Final disease or condition resulting in death)	a. E.	caused the death. each line.	Leal		of dying,		diac or respirat			Approximate Interval Between Onset and Death
8760,		Ilcal Examiner	Sequentially list conditions, and, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d. /12	Cor as a prisoqui Doti C (or as a conseque Doti i	ence of):	e ph	2/0	pat	hy			
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Records, P	w requires that ceen signed b chould be deta	by	Part II. Other significant conditi	ons contributing to d	eath but not result	ting in the ur	derlying car	use given	in Part I.	23e.	Did tobacco		ute to the cause of death?
Vital Reco	ician: The law r certificate has ue rector, page 2 ch	e Completed	25. Was case referred to medica			· · · · · · · · · · · · · · · · · · ·				101		dea	re autopsy findings available in to completion of cause of th? Yes 2 \sum No
of	ing Phys J. After this funeral di	To B	examiner? 1 Yes 2 No 27 Manner of Death Natural 5 Pendir 2 Accident investi	Hospital: 28a. te (Mon		R/Outpatient 28b. Time of Injury		Other: c. Injury al Work?	4 🗆 Nursin	Death (Check of g Home 5 - 28d. Desc			(Specify)
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	To the Hospitel within 24 hours a To the Funerel completely filled	Medical	29a. Certifier (Check only ane) 2 Medical 29b. Signature and Hitle of Certifier	,	a best of my knowl asis of examinationer stated.	ledge, death on and/or inv	estigation, ii	the time, n my opini License n	ion, death o	ace, and due to courred at the t	ime, date and	d place, and	er as stated. due to the cause(s)
•	\mathcal{V}		30. Name and address person	no completed caus			Dorint)	00 5	132	50	J	14,	7, 2004
	Sta Registr		STEVEN SCHWA: 31. Date filed (Month, Day, Year) JUL 12	2004	3001 legistrar's Signatu	HOSPITI	Spor	KIVE		CHEVEI	RLY, M	D 20	785

			For 1 - State Registrar	State of	Marylan		artment o			lental Hy	gien		444	000	0.1
	4		Decedent's Name (First, Middle,	Last)						2. Date of D		. II I	4	3. Time of	Death
	Physici		Donna Louise Her	dman						July 1		ay 2004	Year	1:20	РМ
	/Medio Examir		4a. Facility Name (If not institution,	give street and num	iber)		4b. City, Tov	vn, or Locati	ion of Death			c. County	of Death	1020	
			Holy Cross Hospi	tal			Silve	r Spri	ing		Mo	ontgo	mery		
	Funeral				7. Age (In yrs.	last birthday)	If Under 1 Y Months D	ear If Unays Hou	der 24 Hrs.	8. Date of B	irth	,	9. Birthp	lace (State o	r Foreign
	Director		273-68-8648	1 □ M 21€ F	43	Yrs.	Williams	ays 110u	WIIII.	June 1	5, 1	961	Michi	gan	
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside Ci	ha I imian
	Aaryt Fsho	ö	Maryland Montgom	0.7477										1 🗆 Yes	-
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	with	0	4500 Jenner Cour	+			208				-	ted S			
	ms 23	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	.S. 13. \			Origin? (Sp	ecify Yes or N			- Americ		
g Q	or Ita	큔	1 ☐ Never Married 2 ☒ Marrie	Armed Ford	2 🔀 No					ecify Yes or N Rican, etc.)		Blac	k, White,	etc.	
<u></u>	rai', o	출	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes:		1□Yes 2X	No Spec	cify:			Specify	Whi	te	
2-0	72 hc	Completed	15. Decedent's (Specify only highest	Education		16a. Deced	lent's Usual O	ccupation	most of work	ina	16b. H	Kind of Bu	siness/Inc	lustry	
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and	be fi	Be	17. Father's Name (First, Middle, La Gordon King	ast)						e (First, Middle Santos		n Sumam	θ)		
Ž	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic event, the Madical Examinational be muffied at	ဥ	19a. Informant's Name/Relationshi	(Tiran Reint)		10h Mailia									
Baltimore, Maryland 21215-0036	d2s than trau		Thomas B. Herdma		vd.					al Route Numb ey, Mar				Code)	
<u>ق</u>	Hear Hear tam		20a. Method of Disposition	II/ IIusbai			sition (Name of			Date		ocation -		wn. State	
<u>o</u> E	No Fire		1 🖫 Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe		lale L		natory or other Cemeter		Ju						
₫	artme ortan		21. Signature of Funeral Service Li	- /	- June			•	17, 2	rt A.	Musk	tegon	Fund	higan	ome /
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any Injury or other traumatic evone.		> X/Lm/	11/11/	м00689	Re	ockyill	e, In	c. 300	West land 2	Mont	gome	ry Av	enue,	Onic,
П			23a. Farti Enter the disease, or co	omplications that ca	used the death	n. Do not ente	er the mode of	dying, such	as cardiac	or respiratory a	rrest,			Approximate Interval Betw)
	Physician	1	snock, or reantailure. List or Immediate Cause (Final disease or condition		tatic 1	Man-am	.111	1 T	a Cama				7	Onset and D	eath
	/Medical		resulting in death)		r as a consequ		all cel	.ı Lun	g can	er			/	month:	S
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ŏ	eath certific attending p I for use as	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna	ncy						22d Date	of deliver		
ň	death atter	ciar	in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live bir	th 2 🗌 Fetal nt at time of de	death 3	Other (specify					Mon			ear
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Vitai	ysiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Pla	ace of Death	(Check only					
0	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ No			ER/Outpatient			Nursing Hor	me 5□Resi	dence	6 Othe	r (Specify)		
		on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury		njury at Work?		28d. Describe	how inju	ry occurre	d		
S	ttand death tor: / the f	cat	2 Accident investigat 3 Suicide 6 Could no	t he				1 Yes 2			-				
DIVISION	or Attanater death	Certification:	4 Homicide determine	ed 286. Place of building	of Injury - At ho g, etc. <i>(Specif</i> y	me, rarm, stre	et, factory, off	IC9	,	28f. Location (City or To	Street an wn, State	na Numbe e)	r or Rural	Route Numb	er,
_	spital	ai C	29a. Certifier 1☑ Certifying	Physician: To the b	est of my know	wledge death	occurred at th	e time date	and place	and due to the	cause(s)	and man	nor as sta	tod	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ledicai	(Check only 2 Medical Ex	aminer: On the bas	sis of examinat	tion and/or inv	estigation, in n	ny opinion, o	death occurr	ed at the time,	date and	d place, ar	nd due to t	he cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. Lic	ense numbe	er er		29d. Da	te signed	(Month, D	ay, Year)	
			I for Ca	Chan			D20	367		THE PARTY NAMED IN COLUMN TO PARTY.	T11 T 37	11,	2004		
	10		30. Name and address of person wh				Print)						2004		
			Joel Kalman, M				7d., Ro	ckvil	le, Ma	ryland	208	52			
	Sta Registr		31. Date filed (Month, Day, Year) JUL 15		gistrar's Signal	Ď.	Spor	ls/							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year July 9, 2004 **Physician** 3:49 Albert Theodore Hattenburg рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Montgomery Hospice- Casey House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y April 29, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex Year) 1928 **Funeral** 76 152 M 2 ☐ F 353-20-3257 Illinois Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show an injury or other traumatic event, the Madical Evantrier must be multiply at ORCE. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Kensington 1 ☐ Yes 2 No Maryland Montgomery Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3333 University Blvd. West, #501 20895 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Physicist U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Francis Hattenburg Anne H. Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence W. Hattenburg/ Son 7716 Harvest Hills Court, Mt. Airy, MD 21771 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 14, 20a. Method of Disposition Metropolitan place) 1 Burial 2 Cremation 3 Removal from State 2004 4 ☐ Donation 5 ☐ Other (Specify) Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd. W. Silver Spring, MD 20901 0 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** More than 1 Metastatic Lung Cancer /Medical Due to (or as a consequence of) year **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the attending physician and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Atrial Fibrillation, Congestive Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed page 1 ☐ Yes 2X No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 StOther (Specify) Hospice Facility Certification: To 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA After this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 XNatural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifie 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Menth, Day, Year) 29b. Signature +1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD 20855 Charles Harrison, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

12

2004

32. Registrar's Signature

			1 - For State Registrar	State of Ma	ryland / Depa	artment of H		-	giene Reg. No. 0	04	23896	
	Discontact.		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death	
	Physici /Medic		Donald	Kenneth	Harrelson			July 8	2004		9:58P M	
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or		Death		nty of Death		
			Casey House	Rockville				Montgomery				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last			Months Days Hours Min.		Min. (Month, Da	v. Year)	(, Year) Country)		
	Director		301-20-0033 A		81 Yrs.			April	7,1923	Cal	ifornia	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation					10d. Inside City Limits	
	eho	'n									1 ☐ Yes 2 ☑ No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or Itams 23a or 28a-f show amy Inportants if item 27 is marked other than "natural", or Itams 23a or 28a-f show amy Injury or other traumatic evant. Its Madical Ext. ill ref. is at be mailised at once.	ect	Maryland Montgomen 10e. Street and Number	ry	Roc	kville			10g. Citizen	of What Cour		
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		Funeral Director	14 Marlin Court	2. Was Decedent Ev	vor in II C 12	Was Deceded of Hi	20853	2 (Specify Ves or No		d Stat		
	er de	Š	11. Maritar Status	Armed Forces? 1 ☑ Yes 2 ☐ No	Ver 11 0.3.	If Yes, specify Cuba	in, Mexican, P	n? (Specify Yes or No Puerto Rican, etc.)), (4.1	Black, White,		
21215-0036	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	Yes, Give		Specify:		Spe	Specify: White		
8	within 72 hour lene. than "natural If a Medical Ex	ed	15. Decedent's Educ	WWII	cedent's Usual Occupation			16b. Kind o	16b. Kind of Business/Industry			
5		Completed	(Specify only highest grade	(Give	kind of work done during most of worki DO NOT use retired)		f working		•			
5		E	Elementary/Secondary (0-12)	College (1-4or 5+ 4		Air Ford	ce		Feder	al Gov	ernment	
D	filed Hyg otha ant,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden Sum	ame)		
au	nd 2 should be alth and Mental 27 ia marked r traumatic ev	ToB	Kenneth Harrelson Lillian					an Eicholt	Eicholtz			
Maryland			19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address (Street a	and Number o	or Rural Route Numb	er, City or Tox	vn, State, Zip	Code)	
Š			Mary Annette Harre	lson/Wife	14 Ma	rlin Cour	ct; Roc	ckville, M	D 2085	3		
ନ୍	s 1 a f Hea itam othe		20a. Method of Disposition		20b. Place of Dispo cemetery, crei	sition (Name of	el l	Date	20c. Locatio	n - City or To	own, State	
9	O S = 50		1 ☐ Burial 2 🖾 Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State				7/16/2004	Balti	more,	MD	
Baltimore,	nit. F		21. Signature Funeral Service License	e ()	the same of the same of			Funeral an				
æ	Departing on the poor of the p		1 (Uniters)	De Ma	1	imple Tri O40 Rocks	ibute i	funeral an Pike: Rock	d Crem	ation MD 20	Center 1852	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
			shock, or heart failure. List only on Immediate Cause (Final			1 0					Interval Between Onset and Death	
	Pnysician /Medical Examiner		disease or condition resulting in death)	eal Carci	ınoma			-				
				Due to (or as a consequence of):								
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):								
	death certificate be executed e attending physician and of for use as the burial-transit	Examine	cause. Enter Underlyin Cause (Disease or injury that initiated events									
Ć,		Exa	resulting in death) Last	Due to (or as a consequence of):								
8760,	e be /sicia e bur	cai	d									
68	eath certificat attending phy for use as the	ip e										
Вох		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy					23d. Date of delivery			
	death		in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at ti		Other (specify)			Month		Day Year	
o.	es that the igned by th be detache		9 Unknown	9□Unknown								
ري ص		by P									ne cause of death?	
rds		pa	Prostate Cancer 12 Yes 2 N							3 ☐ Prot	pably 4 Unknown	
00	> 0 0	Set	Congestive Heart Fa				24a. Was an 24b. Were autopsy findings available					
æ	The tav	Completed							autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No			
of Vital Records,	ician: Tector, p	Be C	25. Was case referred to medical	1								
	Physician: rthis certific ral director,	ToB	examiner? 1 ☐ Yes 2X No	Hospital:						y) Hospice		
			27. Manner of Death	28a. Date of Injury 28b. Time of 28c.						how injury occurred		
Division	ospital or Attan hours after deat unaral Diractor: ly filled in by the	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(World), Day	(Monar, Day 18a) M							
Vis.		ill ill ill ill ill ill ill ill ill ill	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		Medical Certification;	4 - Homous	ballaling, etc.	0.17 0.10							
			29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Madicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the H within 24 To the Fi complete		29b. Signature and tittle of dertifier	10		29c. License number			29d. Date signed (Month, Day, Year)			
	/ 500		a DOSHII			N41218			7/9/04			
	5		30. Name and address of person who cor	moleted cause of de	ath (Item 23a) (Type	1			1/1	101		
,	-		Charles Harrison,		Muncaster		d. Rock	kville. MD	20855			
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar								
5	Regist		JUL 1 6 2004	Sher	2 19	Sparks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Oate of Death . Day 2004^{Year} MY TY 11:35P. M **Physician** HANYOK 6, JOSEPH /Medical 4c. County of Death 4b. City, Town, or Location of Oeath 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Greenbelt 38 Lakeside Drive 8. Date of Birth (Month, Day, Year) Aug. 21, 1918 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Oays Hours 1 M 2 □ F 176-14-6898 85 Yrs. Pennsylvania Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b County 10a State r than "naturel", or Items 23a or 28a-f show the Medical Examinational be notified at 1 XYes 2 □ No Maryland Prince George's Greenbelt Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 38 Lakeside Drive 20770 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status e filed within 72 hours after of Hygiene. other than "naturel", or Itel TYes 2 No Yes, Give 1 Never Married 20X Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: lf Yes, Give Year or Dates: WWII δ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1-4 F.C.C. Electrical Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be filt Depertment of Health and Mental Hy Importent; if Item 27 is marked oth any liuty or other treumatic event one. To Be Hanyok Pauline Michael Keblish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 38 Lakeside Drive Greenbelt, Maryland 20770 Cecelia R. Hanyok -wife 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition v injury o. nlace 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery 7/12/2004 Cheltenham, Maryland A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4400 Powder Mill Road Beltsville, Maryland 20705 el 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebral Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the use as for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the et d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Mitral Valve Prothesis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2X No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. P 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Inpatient 2 EP/Outpatient 3 DOA 1 Tyes 2 XNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation the 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of any knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number D0020072 29b. Signature and title of centiler July 7, 2004 30. Name and address of person who completed cause at ath (Item 23a) (Type, Print)

Registrar

State

Sudhakar Punja, M.D.

JUL 14 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

7219-B Hanover Parkway Greenbelt, Maryland 20770

			For State	State of Maryland					201	71. 22000	
			Registrar		Cer	tificate of	Death	2. Date of Dea	Reg. No. U	3. Time of Death	1
	Physicia	an	1. Decedent's Name (First, Middle, Last) HARRIET	B. HANB	ACK			Month	Day	Year 1:45 A M	1
	/Medic Examin		4a. Facility Name (If not institution, give s		7,010	4b. City, Town,	or Location of Deat		4c. County of		
	Examin	er	MILLENIUM HEALTH		ION	SILVE	RSPRING		MONTO	GOMERY	
	Funeral		5. Social Security Number 6. Sex			If Under 1 Yea Months Days		(Month, Day	/ Year)	Birthplace (State or Foreign Country)	n
	Director		220 28 5012	M 254 82	Yrs.			Aug. I	0°1921	Washington,D.C	•
land	M to		10a. State 10b. County		, Town or Lo					10d. Inside City Limits	
Мал	4 4	tor	Md. Montgom	ery Si	lver S	pring				1 ☐ Yes 2 🗷 No)
th the	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W		
ath wi	23a		2421 Bel Pre Road			20906				ed States	
er de	Items Gr.D	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No	S. 13. V	Vas Decedent of f Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Black	e - American Indian, k, White, etc.	
Jrs aft	vari	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2M No	Specify:		Specify:	White	
be filed within 72 hours after death with the Maryland	natur lical	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deced	lent's Usual Occi	upation a during most of wo	rking	16b. Kind of Bu	siness/Industry	
ithin it	Jan "t	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retir	e during most of wo ed)		County	/ Schools	
jed v	Hygier ther ti		9 17. Father's Name (First, Middle, Last)	0	bus	Driver	18. Mother's Na	me (First, Middle,			_
d be f	kad of	To Be		tle			Harrie		Greer		
2 should	Department of Health and Mental Hygiene. Important: or Items 23e or 28e-f show Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Eventine must be notified at once.	-	19a. Informant's Name/Relationship (Ty				e Road, S				
1 and :	lealth am 27 jhar tr		Jacquelyn A. Short	20b. Pi	lace of Dispo	sition (Name of	<u>-</u>	Date Date		City or Town, State	_
Pages 1 and	A I I I		1 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	Removal from State	emetery, cren	natory or other pl lle Unio		17/04	Burtons	sville, Md.	
Dalt. P	oartme sortan / injur 28.		21. Signature of Funeral Service License				ress of Facility H. Barber		Home		
Š	B is is on		murie V.	Burber		P. 0.	Box 5038,	<u>Laytons</u>	ville, N		_
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.			ring, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death	
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		FAILURE	*				_
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):						
ecuted	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	STROKE Due to (or as a consequ	ience of):						
	ohysician and the burial-transit	al E		SMALL VESS		FARCTS					
dicate	g phys	edical		1							_
S Cont	ending use	M/UE	23b. was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnan	cv		23d. Date Mon	e of delivery oth Day Year	
e deat	the att	Physician/M	in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	4 Pregnant at time of de 9 Unknown		Other (specify)			Mon	iii Day 19ai	
thatth	certificate has been signed by the attending prector, page 2 should be detached for use as		Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the ur	nderlying cause o	pven in Part I.	23e. Did to	bacco use contri	ibute to the cause of death?	
CICS,	n sign ald be	d by	DEMENTIA					1 🗆 Y	′es 2□No	3 Probably 4 Munknown	1
S 8	s bee 2 shor	Completed	PARKINSON'S	DISEASE				24a. Was autop		Vere autopsy findings available rior to completion of cause of	3
T Per	ate ha	mo						perfor	rmed? d	eath? □ Yes 2□ No	
	artifica octor,	Be	25. Was case referred to medical examiner?					ath (Check only or	пе)		
Physic C	this c	To	1 ☐ Yes 2 Sk No	lospital: 1 Inpatient 2 2	ER/Outpatien 28b. Time of	I 3LI DOA		Home 5 Resid	lence 6 Othe		_
gi g	h. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	W	ork? □Yes 2□No		,		
OIVISIOII	er death. actor: Atter this certificate has by the funeral director, page 2	ertification:	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office	9	28f. Location (S City or Tow		er or Rural Route Number,	
	rs afte al Dir ed in	Cert	4 Tromode	Dunging, stc. (opecn)							
DIVISION OF VICE RECOIDS, F.C. BOX 00/00, for the Hospital or Attanding Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sician: To the best of my kno iner: On the basis of examinal and manner stated.	wledge, death tion and/or in	n occurred at the vestigation, in my	time, date and plac opinion, death occ	e, and due to the durred at the time, o	cause(s) and mar date and place, a	ner as stated. nd due to the cause(s)	
the c	o tha omple	Mec	29b. Signature and title of certifier	and married stated.		29c. Lice	nse number	ļ.	29d. Date signed	(Month, Day, Year)	_
-	2. 0		+ Bom	() m		D	51520	GA .	7-14	-04	
	3		30. Name and address of person who co		23a) (Type,	Print)	TTE 0 43	CILVED	CDDING	MD 20002	
	,		BAHRAM PISHDAD, I			AVE., SU	11E 3-41,	21LAFK	SPKING,	MD. 20902	-
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	4	Soork	11				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JULY 7, 2004 **Physician** CLARENCE HAAVE 16:00 PM RAYMOND /Medical 4c. County of Deeth Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 2 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 X M 2 T F 90 476 01 5397 Minnesota Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rai', or items 23a or 28a-f show Exemples must be notified at 1 Yes 2 No Montgomery 01nev Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20832 United States 3617 Oueen Mary Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: WW I 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other treumatic event, the Medical Exertical 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No I I WW Specify Specify: White þ 3 → Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 4 Physicist Science 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Haave Carl 0. Anna Schossow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3153 Beaverwood Lane, Silver Spring, Md. 20906 Elizabeth H. Dougherty/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State *4 □ Donation 5 □ Other (Specify) Metropolitan Crem. 7/9/04 Alexandria, Va. 21. Signature of Funeral Service Licenses Muriel H. Barber Funeral Home P. U. Box 5038, Laytonsville, Ba muri 20882 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to animediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit nding physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Fetopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the a 9□ Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 1 Inpatient Certification; To 28a. Date of Injury (Month, Day Yeer) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the hours after deat 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 T Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier JULY 8, 2004 D0055694 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 OLNEY LAYTONSVILLE ROAD, OLNEY, MD. ALOK MATHUR, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks 2004 12 Registrar

			For State	State of Marylan					viental Hy	giene	9	
			Registra AMEND IIEM #	26 PER VERB G	7/29	HOWINGE	e of l	Death	2. Date of De	Reg. No	2004	2 3 0 0 0
	Physicia	an .	1. Decedent's Name (First, Middle, Last)				0		Month	Da		
1	/Medic	al	FRANK 4a. Facility Name (If not institution, give s		NDE	RSON 4h City	Town or	Location of Death	MAY_	2 3	. County of Dea	
	Examin	er		SE HOSPIT	n1			EVERL		1	PRIN	
	Funeral			7. Age (In yrs.			1 Year	If Under 24 Hrs. Hours Min.		th Vear		thptace (State or Foreign ountry)
0.64	Director		578-26-7/64 1X	M 20F 78	Y	rs.	Days	Hours Mair.	C	6,19	25 No	RTH CAROLINA
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town	or Location						10d. Inside City Limits
	Maryli f sho	ō	MARYLINAN Parille	GEORGE	1	ANDO	/ED					1 Yes 2 □ No
	1 28a-	Directo	MARYLAND FRINCE 10e. Street and Number	OEUNGE		10f. Zip			-	10g. Ci	tizen of What C	ountry?
	h with	al D	7413 GRAY	RIDGE LA	NE		20%	785		UN	TTED	STATES
	ems ems	Funeral		12. Was Decedent Ever in U.		13. Was Deced	dent of H	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.))-	14. Race - Am Black, Wh	erican tridian,
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 X Yes 2 No 19	40	1 ☐ Yes		Specify:			Specify:	INAL
0	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Madical Examiner must be notified at	ed b	15. Decedent's Edu		16a.	Decedent's Usua	al Occup	ation		16b. K	(ind of Business	LACK Vindustry
21215-0036	nin 72 in "in	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)		Give kind of wo life. DO NOT u	rk done i	during most of wor	rking			
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nd	be filed htal Hygi od other svent, il	Be	17. Father's Name (First, Middle, Last)	_				18. Mother's Nar		1 1		
Z	should nd Men marke	2	NATHANIEL HE	NDERSON	10b	Mailina Addrasa	(Stead	JUAN and Number or Ru	ITA			Zin Codo)
Maryland	d 2 sh th and th and 7 Is r		19a. Informant's Name/Relationship (Ty	DAUGHTER	1 50.	200 A	Calledia	- LINE A.	. 1		۸	180, Md.20772
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itsm 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic svent, the Medical Examiner must be notified as once.		20a. Method of Disposition	20b. F	Place of	Disposition (Nar crematory or o	ne of	EN HO IV	Date		ocation - City o	
9	Pages nent of int: #f it irry or o		1 Burial 2 □ Cremation 3 □ R 1 Other (Specify)	lemoval from State	-	· · · · · · · · · · · · · · · · · · ·			= 7 2004	ARI	INGTO	N. VA.
Baltimore,	permit. Page Department of Important: if any Injury of once.		21. Signature of Funeral Service License	** 1. 0 00		22. Name ar	d Addre	CNAL JUN ss of Facility Po	OPE FUN	IERA	IL HOM	ES
<u>m</u>	88 = 8		(wa)	Wikely							TVILL	E, MD 20747
Ų,			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat to cause on each line.	h. Don	ot enter the mod	le of dyin	ig, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		1	Due to (or as a conseq	uence o	A	ERY	DIS	EACT			
1	gill 20. jan	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence o			D-4-31	N/TSE			
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	HYPER	TEN	15 IO	1					
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Box	death cert	Iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		3 □Ectopic pi 5 □ Other (sp		<i>'</i>			Month	Day Year
P.0.	t the by th ache	Physician/M	9 Unknown	9□ Unknown								
	res tha signed l	by F	Part II. Other significant conditions con	stributing to death but not res	ulting in	the underlying o	ause giv	en in Part I.				o the cause of death?
ord	law requires as been sign 2 should be								10	Yes 2	I No 3 A	robably 4 Unknown
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10	를 들 필	 -	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. T		28c. Injur Wor	y at	28d. Describe			50,197
Ö	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Bay 1 sar)		М		Yes 2 □ No				
Division	or Atta	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specific		m, street, factor	y, office		28f. Location (City or To			Rural Route Number,
0	pltat o	S	29a. Certifier 1 Certifying Phy.	sician: To the best of my kno	władze	death occurred	at the tie	no, data and place	and due to the	causa(s	and manner a	e stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ation and	Vor investigation	i, in my o	pinion, death occu	urred at the time.	, date an	d place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. (//	1			e number			ate signed (Mor	
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12	15/11/		30. Name and address of person who			Type, Print)	Sui	te 200	Oxon H	iiI_{j}		
	114	to	31, Date filed (Month, Day, Year)	2. Registrar's Signa	(olature		KON	THE LL	MINID.	207	45	
	Sta Regist		MAY 2 7 2004	Bloke K	1							

20a. Method of Disposition Comparison C				1 - For State Registrer	State of N	Maryland	•	artment of F rtificate of		and Mer	ntal Hygier	2001	23901
TOTAL DISCORDER SECTION TO THE CONTROL OF THE PROPERTY OF THE				1. Decedent's Name (First, Middle, L.	ast))av Year	
## Courty of Deans State Text Courty of Deans State State Spring Spring State Spring Sta				Juliana W.	Harn	rell				_			
South Secret Number Case 7.78 10 m/s/c 10 m/s				4a. Facility Name (If not institution, gi	ve street and number	∍r)		4b. City, Town, o	or Location o	of Death	4	c. County of De	ath
The state of the s				Fox Chase Nursing	g Home					-	M	ontgome	ry
Description Color		Funeral			4 T 44 OV F		t				Date of Birth (Month, Day, Yea	9. Bi	irthplace (State or Foreign Country)
10a Sale 10a County 10a C		Director		223 66 3/19	1 A 2 A 7	'3	Yrs.						hina
Section Charles Continued Continue		pur				10c City	Town or Lo	cation					10d Inside City Limits
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Section Charles Continued Continue		er de	n		Armed Force	s?	5.	f Yes, specify Cub	an, Mexican	, Puerto Rica	in, etc.)		
Section Charles Continued Continue	36	rs aft			If Yes, Give	S:		1 ☐ Yes 2X No	Specify:			Specify:	Asian
Section Charles Continued Continue	ᇢ	hou	edi			-	16a, Deced	tent's Usual Occur	pation		16b.	Kind of Busines	s/industry
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Section Charles Continued Continue	7	the end	E C	1 2	2 College (1-40	or 5+)	Hon	nemaker			Ov	vn Home	
The control of the co	ס	Hyg other		17. Father's Name (First, Middle, Las	1)				18. Mothe	r's Name (Fi	rst, Middle, Maide	en Sumame)	
The state of the s	<u> </u>	0 7 >	0 B	Chaing Woo					Unkn	own			
The state of the s	2	shou nd M mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address (Street	and Numbe	or or Rural Ro	oute Number, City	or Town, State,	Zip Code)
Donation 5 Don		od 2 1th a 27 Is r trau		Robert W. Harrel	1 - Spous	e :	5705	Glamis T	rive	Alevan	dria VA	22315	
Donation 5 Don	စ်	Hea Hear tern othe		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of		Date	20c.		r Town, State
232 Part Lighter that disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arries. Pity solicion (Modifical Examiner) Pity solicion (Modifical Examin	2	t: F				(6)	·		10	une 29	,04 Ale	xandria.	. VA
232 Part Lighter that disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arries. Pity solicion (Modifical Examiner) Pity solicion (Modifical Examin	ቜ	artme orten injur					_		_	y Jeff			
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Pityslicin Middleal Examiner The proposed and place in the proposed program in the program of t				23a. Part 1. Enter the disease, or cor	nplications that caus	sed the death.	. Do not ente	er the mode of dyir	ng, such as	cardiac or re	spiratory arrest,		Approximate
State Manual College Part				shock, or heart failure. List only	y one cause on each	n line.			J.				
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The control of the		and and I-trar	хап	that initiated events	c. Due to (or	as a conseque	ence of):		· · · · · · · · · · · · · · · · · · ·				
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25. Was case referred to medical examiner?	BO	atten for u	ian	in the past 12 months?	1 Live birth	2 Fetal	death 3 □		y				•
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25. Was case referred to medical examiner?	۵.	that i ed by deta	ď.	Part II. Other significant conditions	contributing to death	h but not resul	lting in the ur	nderlying cause giv	en in Part I.		23e. Did tobacco	use contribute	to the cause of death?
25. Was case referred to medical examiner?	ds,	sign d be	d b	HYPERTE	NSION						1 ☐ Yes	2 □ No 3 □ F	Probably 4 Nunknown
25. Was case referred to medical examiner?	ò	requ	ete	PERIPHER!	WAC	2111	12	DISTAC	15		240 1460 00	24h Wasa	uutanay findinga ayailahla
25. Was case referred to medical examiner?	န္တ	elaw has je 2 s	ם	18FIRMERA	TL VAS	× UL	1+1	D (32/15)	×1-		autopsy	prior to	completion of cause of
29a. Certifier Check on 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrar's Signature 33. Date filled (Month, Day, Year) 32. Registrar's Signature 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrar's Signature 36. Date filled (Month, Day, Year) 36. Date filled (Month, Day, Year) 36. Registrar's Signature 36. Date filled (Month, Day, Year) 36. Date filled (Month,	=												s 2 XNo
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Registrar JUL 12 2004 Server & Sports				Dr. Ravi Passi	32 Régi					ring,	MD 20910		
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		_	For State	State of Maryland / D	epartment of He			00	nı (22002
			1. Decedent's Name (First, Middle, La.		Certificate of E	Jean	2. Date of De Month	ath Day	Vane	3. Time of Death
A	Physicia /Medic		Arthur Le				July	11,2	co4	1935 M
3	Examin	er	4a. Facility Name (If not institution, give	1 1 1 1 0 1	4b. City, Town, or I	Location of Death	4	1	y of Death	undel
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birt		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th Year)		ace (State or Foreign try)
	Director		217-40-0603	52 SAM 20 F	frs. Moritins Days	Hours Min.	625	-52		yland
	dand dand	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location	_			10	Od. Inside City Limits
5	ith the Marylan or 28e-f show	ctor	MD Queen	Anne's Cl	nester					1 ☐ Yes 2 ☑ No
\mathcal{L}	vith the	Dire	10e. Street and Number	0 A Q × 1111	10f. Zip Code	/ 10		10g. Citizen of	What Count	try?
Z	ours after death with the Maryla raf', or Itams 23a or 28e-f shov Examination at the motified at	Funeral Director	111-Lee Road	12. Was Decedent Ever in U.S.	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	city Yes or No	- 14. Ra	ice - America	
ဖွ	after or Itan	Fun	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 ☑ No	If Yes, specify Cubar	Specify:	Rican, etc.)	Spec	ack, White, e	etc.
215-0036	within 72 hours after death with the Maryland ene. than "netural", or Itams 23e or 28e-f show f a Modical Exercilier (- ust be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	If Yes, Give Year or Dates:	Decedent's Usual Occupa			16b. Kind of I	13/0	-CK
215	nin 72 In "nel	Be Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done do life. DO NOT use retired)	uring most of worki	ng	755. Kind 51	3430340	,
2	ed with ygiene yer tha t, the	Com	12	(5	roundsk			Nava	1 Ac	adeny
Maryland	permit Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than 'netur any injury or other traumatic event, If a Modical once.		17. Father's Name (First, Middle, Last			18. Mother's Name	(First, Middle)			/
aryl	should nd Me mark mark	2	19a. Informant's Name/Relationship (Mailing Address (Street a	and Number or Rura	I Route Numb	er, City or Town		Code)
	and 2 salth a n 27 ls er tra		Mary Jo	nes 11	1-Lee Road.		11406	ester	2,MI	0.21619
ore	t of He If itan or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place of cemeter	Disposition (Name of y, crematory or other place	9) ,~ / ,	ate	20c. Location	1000	wn, State
Baltimore,	urmen rrent: njury		4 ☐ Donation 5 ☐ Other (Special21. Signature of Funeral Service Lices		SUN'S CEMET	PRU.	,	GRASI	nVil	le, MD.
Ва	permii Depar Impor any ir		Danello	C. Henry	HEWRY F	uneral hington	HOME,	anbri	dereil	np. 2161=
			23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do none cause on each line.			r respiratory a		97	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a_Myrcardia	2 Injonet	ion				Onset and Death
	/Medical Examiner		resulting in death)	Due to (IV as a consequence	on the	alasho	Lou Da	1)E	(310)	Unio
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence	of):	W(11000		c offe		JEMCS.
	cuted nd transit	Examiner	that initiated events	· Diabetes	Mellitu	1. ty	ne of	٠ '		Years.
,092	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequence	of):					1
687	or Attanding Physician: The law requires that the death certificate be executified to the death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-tran	Physician/Medicai		d						
Вох	aath certif attending for use as	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐Ectopic pregnancy				ate of delive	*
O. B	es that the death certific igned by the attending F be detached for use as	sicis	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			N	lonth	Day Year
P.0.	that thed by detacl			contributing to death but not resulting in	n the underlying cause give	en in Part I.	23e. Did t	obacco use co	ntribute to th	e cause of death?
rds,	quires tha n signed uld be de	ed by	RENA	Tailue			10	Yes 2 No	3 🗌 Proba	abiy 4 Unknown
900	e law requir has been s je 2 should	piete		V			24a. Was	an 24b	. Were autop	osy findings available inpletion of cause of
Ä	The late ha	Completed					perfo 1 ☐ Yes	200 No	death?	2 No
Vita	ding Physician: The n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Othe	26. Place of Death				
of	y Phys er this eral di	n; To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury 28b.	Fime of 28c. Injury	4 Nursing Ho		how injury occu		")
ion	ittanding F death. stor: After / the funer	atio	1 Natural 5 Pending investigation	n		Yes 2 □ No				
Division of Vital Records,	l or Attan after deat Diractor:	ertification;	3 Suicide 6 Could not to determined		rm, street, factory, office		28f. Location (City or To	Street and Nun wn, State)	nber or Rurai	l Route Number,
	To the Hospitel or At within 24 hours after or To the Funaral Dirac completely filled in by	O	29a. Certifier Certifying P	hysician: To the best of my knowledge	, death occurred at the tim	ne, date and place,	and due to the	cause(s) and n	nanner as st	ated.
	To the Hospitel within 24 hours a To the Funeral completely filled	edical		miner: On the basis of examination an and mapper stated.						
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License	number		29d. Date sign	ed (Month, L	Day, Year)
			Marker 1	· Clefting	W 10-00	112061	2	July	12,	2007
			30. Name and address of person who	ADAMO MD	Type, Print) Admiral	PCochra	ine: A	WUAD	olis.	MD 2140/
•		ate	31. Date filed (Month, Day, Year) 4	2004 32. Agistrar's Signature	hours.		3			
	Regist	ar		LANGERED YO.	Marie					

Division of Vital Records, P.O. Box 68760. hin 24 hours a Hospital 0

State

Registrar

(Check only one)

29b. Signature and title of certified

30. Name and address of pers JACK M.

31. Date filed (Month, Day, Year)

JUL

13 2004

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

29c. License number

111 Penn Street, Baltimore, Maryland 21201

OCME

29d. Date signed (Month, Day, Year)

July 11, 2004

State of Maryland / Department of Health and Mental Hygiene

				Otate of 14	arylari	Certifica				Reg. No.	11. 2	3001
	1		1. Decedent's Name (First, Middle, I	Last)					2. Date of De	Dey	Year	3. Time of Death
	Physicia		Mae B. Kelso						July	09 200	4	9:00 PM
	/Medica Examine		4e Fecility Neme (If not institution, g	ive street and number)			4b. City, Town, or	Location of Deat	h 4c. County	of Deeth	
4	Examine		Dennett Road	Manor Nurs	ing H	ome		0ak1an	1	Ga	rrett	
	Funeral Director		5. Social Security Number 220-10-0341	Sex 7. A 1 □ M 2 X F	ge (In yrs. la	Month	er 1 Yea 5 Day:		(Month, Da	th ay, Year) .2, 1916	9. Birthple Countr Mary	ece (State or Foreign ry) 1 land
	P .	- 1-	Usuel Residence of Decedent 10a. State 10b. County		10c City	, Town or Location					10	d. Inside City Limits
	the Marylar 28e-f show	<i>i</i> 1	MD Garre	tt		land						1 ☐ Yes 2√G√No
	th with th	Funeral Director	10e. Street end Number 1113 Mary Drive				ip Code 2155			10g. Citizen of USA	Whet Countr	y?
900	Lrs a	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ፟፟ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	S. 13. Was Dec If Yes, sp		Hispenic Origin? (S ban, Mexican, Puerl o Specify:	pecify Yes or No o Rican, etc.)	Bla	ce-America ck, White, et y: Whit	tc.
Maryland 21215-0036	within 72 hours ene. then "netural", he Medical Ex	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12) 12th	Education rede completed) College (1-4or	5+)	16a. Decedent's Us (Give kind of v life. DO NOT Homemak	rork don use retir	upetion e during most of wo red)	rking	16b. Kind of B	usiness/Indu	
7	Hed v tygie her t	ပ္ပ	17. Father's Neme (First, Middle, La	o#)		пошешак	:1	18 Mother's Nar	ne (First Middle	, Maiden Sumar		3
and	mtal h	o Re	Oliver Beachy	51)					a Thomas		,,,,,	
Ž	d Me	2	19a. Informant's Name/Relationship	(Type Print)		19h Mailing Addre	es (Stroi	et and Number or Ru			State Zin (Code)
Ma	d2s than 7 is 1	1	Eileen W. Snyder			474 Snyo			land, MI		, orano, zap c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
<u>a</u>	Heel Heel other	-	20a. Method of Disposition	/ dadgirect	20b. Pl	ace of Disposition (Nametery, cremetory of			Date	20c. Location	- City or Tow	m, State
Baltimore,	Peges mant of mant: If it		1⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		3	tinger Ce	nete	ry 0	7/13/20	04 Bit	tinge	r, MD
Ball	permit. Peges 1 and 2 should be filled with Depertment of Heelth and Mental Hygien important: If item 27 is marked other the eny injury or other traumetic event, the parce.		21. Signature of Funeral Service Lic	ensee		Newma	n Fu	ress of Facility neral Hom r Street,				536
	2121		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each	ed the death line.	. Do not enter the m	ode of dy	ring, such as cardia	or respiratory a	rrest,	1	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)	a Atheros		tic Heart		ease			у	ears
		e e			200 10 (0.	00 4 0011004001100 0	.,.				1	
, 0,	rificate be axecuted g physicien and as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury	b	Due to (or	es e consequence o	·):				1	
x 68760,	death certificate be axecu e attending physicien and id for use as the burial-trai		that initieted events resulting in death) Last	d	Due to (or	as a consequence of):		-			
Вох	ath c for us	Physician										
	the a	38	Part II. Other algnificant conditions	contributing to death I	but not resu	Iting in the underlying	cause	jiven in Part I.	23b. Did	tobacco use co	ntribute to t	the cause of death?
s, P.O	£ 9 0	Dy Fin	Diabetes Mellity	ıs Type II					1	Yes 2X No	3 Probe	ably 4 Unknown
of Vital Records,		Completed							24a. Wes	an autopsy ormed?	avai	e autopsy findings lable prior to apletion of cause eath?
<u>=</u>	Tha is	5							10	Yes 2√2 No	10	Yes 2□ No
Vita	clan: entific ector	9	25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		ED/Outrobiest 201	000	Whor:	ath (Check only			
o o	5 00	2	27. Manner of Death	28a. Dete of Ini	urv	ER/Outpatient 3□ I 28b. Time of	28c. Inj	4 X Nursing r	T	dence 6 Oth how injury occur		
9	dlng th. Afte		1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Di	ey Year)	Injury M		ork? ⊒Yes 2⊒No				
Division	To the Hospital or Attending Phywithin 24 hours aftar deeth. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could not determine	d 28e. Piece of in	njury - At hor tc. (Specify)	me, farm, street, facto	ory, office	9	28f. Location (City or To	Street and Numl wn, State)	ber or Rural	Route Number,
	e Hospital	edical	29a. Certifier 1 ☆ Certifying I (Check only one)	Physician: To the best aminer: On the basis of and manners	of exeminati	rledge, death occurre on end/or investigation	d at the	time, date end plece opinion, death occu	e, end due to the urred at the time,	cause(s) and made and place,	anner as sta end due to t	ted. :he cause(s)
	within To th		29b. Signature end title of certifier	1)		2	9c. Lice	nse number		29d. Date signe	d (Month, D	ay, Year)
)			· +/10	the	_		D15	333		July 9,	2004	
			30. Name end eddress of person wh Thomas G. Johnson			23a) (Type, Print) Fourth St	reet	0akland	, MD 2	1550		
	State	9	31. Dete filed (Month, Jay Year)	2004 32. Regist	rer's Signat	ure Show	30					

DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7, July 2004 4:00 A^{M} Juliet Fisher Kidney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George Collington Episcopal Lifecare Mitchellville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. NoV. 93. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 90 Yrs Richmond, IN Director 270-12-2800 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23e or 28e-f show The Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Prince Georges Mitchellville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10450 Lottsford Rd. 20721 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed by 3 X Widowed 4 □ Divorced ear or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5 College (1-4or 5+) Elementary/Secondary (0-12) Economist Department of Labor other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth any Injury or other treumatic event once. Be Edgar Fisher Florence Corwin 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3030 North Harrison St. Arlington, VA 22207 James Kidney - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mt. Comfort Crem. July 9, 2004 Alexandria, VA * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave., Nw Washington, DC 20016 9 **一**多. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Tary, belong to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 XNo 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by ta should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Warsing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 2 ER/Outpatient 3 DOA 2 this s efter death, Il Director: After this Id in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending Injury 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) within 24 hours e To the Funerel I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2 MA D47603 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 Mitchellville Rd. B216 Bowie, MD 20716 William DuBoyce, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State sacks! greene

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 11, Day 2004 **Physician** 10:10 pM Ooui Kha /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Montgomery Hospice-Casey House Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year
July 13, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕅 F Ĩ⁄915 China 219-19-5224 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Counts ir Items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Silver Spring Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20902 1511 Windham Lane death Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after ☐Yes 2X No 1 Never Married 2 Married Asian ŏ 1 ☐ Yes 2 Ho Baltimore, Maryland 21215-0036 Specify: Specify If Yes, Give Year or Dates: the Medical Exer ð 3 XWidowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Is markad Yue Chow Tieu Kha 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1511 Windham Lane, Silver Spring, MD 20902 Health : Kinchi Wong/ Son othar 20b. Place of Disposition (Name of 20c. Location - City or Town, State July 14. 20a. Method of Disposition cemetery, crematory or other place)
Metropolitan Department of Important: If it any injury or o 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 2004 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Crematory Francis Address of Each line Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signati of Juneral Service Licens Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final More than 6 Months Gastric Carcinoma with Metastasis to Liver & Kidneys Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Tes 2 No 3 Probably 4 Nunknown been si Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 performed page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No certificate After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 Residence 6 10 Other (Specify) Hospice Certification: To 1 Yes 2X No Facility 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 XNatural 5 Pending To the Funaral Director: Aft
To the Funaral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the D4121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

M HAR RISON,

2004

15

Charles M HAR

31. Date filed (Month, Day, Year)

JUL

M.D.

32. Begistrar's Signature

6001 Muncaster Mill Road, Rockville, MD

20855

			For Stata Registrar	State	of Marylar		artment of F <i>rtificate of</i>			ntal Hy	giene Rag. No	001	23907
			Decedent's Name (First, Mide	dle, Last)				_	2	. Date of De	eath		3. Time of Death
	Physici		Janet M.	Kelly					3	$\mathop{ ext{July}}^{ ext{Month}} 1$.0, Da	2004 Year	11:25P M
	/Medic Examin		4a. Facility Name (If not instituti	on, give street and n	umber)		4b. City, Town, c	or Location	of Death		40	. County of Dea	ith
			Shady Grove A	dventist I	Hospital	L	Rockv	ille			N	iontgome	ery
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔏 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	Min.	Date of Bir	ay, Year)	9. Bi	rthplace (State or Foreign ountry)
	Director		107-34-2640	1 M 263F	(50 Yrs.				Jan. 2	1,19)44 Ne	w York
	pu *		Usual Residence of Decedent 10a. State 10b. Count	tv.	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	sho	5		tgomery			mery Vil	1age					1 X Yes 2 □ No
	28a-f	Director	10e. Street and Number				10f. Zip Code				10a. Ci	tizen of What C	ountry?
	with a or	ā	19008 Stedwi	ck Drive			2088	6				ted Sta	
	eath	Funeral	11. Marital Status		cedent Ever in U	J.S. 13.	Was Decedent of H		igin? (Specif	fy Yes or No		14. Race - Am	
10	r Iten	FE	1 ☐ Never Married 2 ☐ Ma	Armed F arried 1 ☐ Yes	2 [X] No					can, etc.)		Black, Whi	
21215-0036	72 hours after death with the Maryland natural', or Itema 23a or 28a-f show Jical Examiner must be notified at	by	3 ☐ Widowed 4 X Divorce	ed If Yes, G	live Dates:		1 ☐ Yes 2 🔀 No	Specify:	•			Specify: Wh	ite
9	72 ho	Completed	15. Decede	ent's Education lest grade completed	()	16a. Dece	dent's Usual Occup	pation during mos	st of working	,	16b. K	(ind of Business	s/Industry
21	within and the state of the sta	nple	Elementary/Secondary (0-12)		(1-4or 5+)		kind of work done DO NOT use retire	id)			_		
	e filed within at Hygiene. other than vent, the Me	Co				Teac	her	10 11-15		Fire Address		ducatio	n
pu		Be	17. Father's Name (First, Middle						er's Name (i			i Sulliame)	
yla	2 should be and Mental Is marked o	2	John Love Kel	-		401 44 15			ebecca			as Taura Ctata	Zin Code)
Maryland	2 sh and 1 sm raum		19a. Informant's Name/Relation				ng Address (Street						
di.	es 1 and 2 should b of Health and Ment: fitem 27 is marked grother traumatice		Matthew Alegi 20a. Method of Disposition	(Son)	20b.	Place of Dispo	Delmont Delmon					ocation - City or	0912 r Town, State
יסר	Tit it		1 Burial 2 Cremation		n State Me	cemetery creater CTOPOI	matory or other pla itan		July ^{Dat} 2004	٦,			
Baltimore,	urtme		' 4 □Donation 5 □ Other 21. Signature of Funeral Service		Cr	emator	y 2. Name and Addre			1 17			, Virginia
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot		Custu &	Don			10 E. De						MD. 20877
			23a. Part1. Enter the disease,	or complications that	caused the dea							200428,	Approximate Interval Between
ı	Physician		shock, or heart failure. Li Immediate Cause (Final	st only one cause on	each line.	LUA	16 C	ANI	160	1			Onset and Death
	/Medical		disease or condition resulting in death)	aDue to	o (or as a conse	quence of):		100	00/				JERIJ
	Examiner		Constally link and distance	Ь									
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30,	e executan a	Ě	resulting in death) Last	Due to	o (or as a conse	quence oi):							
68760,	icate be executed physician and s the burial-transit	edical		d								_	
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Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Fet	al death 3	☐Ectopic pregnanc☐ Other (specify) _	y:				Month Month	Day Year
o.	at the de by the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk			_ Gallor (opcomy) _						
<u>α</u>	that the ded by detain		Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	ınderlying cause gı	ven in Part	I.	23e. Did	tobacco	use contribute 1	to the cause of death?
Records,	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use a	d by								1 🕞	Pes 2	□No 3□P	robably 4 Unknown
COL	w require been si should I	lete								24a. Was			utopsy lindings available
Re	The lavate has	Completed								auto perfe 1 ☐ Yes	ormed?	death?	completion of cause of s 22 No
Vital		0	25. Was case relerred to media	cal				26. Place	e of Death (1		1010	3 22 110
>	Physician: this certificantal director,	0 B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Depatient 2	ER/Outpaties	nt 3 DOA Ott	har				6 □Other (Spe	ecify)
1 of	g Ph	L:U	27. Manner of Death	/8.40	e ol Injury onth, Day Year)	28b. Time o	of 28c. Inju Wo	iry at	28	d. Describe	how inju	ry occurred	
ior	Attending I r death. ector: After by the funer	atic	Z Accident	stigation				Yes 2]No				
Division	after death Director:	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 200. Plac	ce of Injury - At I Iding, etc. <i>(Spec</i>		reet, lactory, office		28	f. Location (City or To			Rural Route Number,
	oltal ours af			· Braider Tal			4 4 4 4					\d	o state of
	To the Hospital or / within 24 hours after To the Funeral Direction completely filled in b	edical		ying Physician: To the ai Examiner: On the and ma									
	To the within 2 To the complet	Me	29b. Signature and title of certi				29c. Licens	se number	1		29d. Da	ate signed (Mon	th. Day, Year)
			MA	1 1/2	-, 11	0	5	161	6		0	7-10)-2004
•	10		30. Name and address of person	on who completed ca	use of death (Ite	m 23a) (Type,	Print)				,		
			Helson &	Lalil	18111	Vini	ce Philip	Vr 7	432	1,01	No,	1208	32
	Sta		31. Date liled (Month, Day, Yea	2004	Registrar's Sign	ature 4	Som V.				,		
	Regist	di	JUL I 4	LUUT /~	7	14	Lake a calot						

KELLT, JANET M.

			1 - For State Registrar	State of N	1arylan	_	artmen				lental Hy	/giene	1001	220	00
			1. Decedent's Name (First, Middle, La	ist)							2. Date of D	eath		3. Time o	f Death
	Physic /Medi		MILDRED L. KAUFFN	IAN							JULY	Da:	y Yea 2004		A M
	Examir		4a. Facility Name (If not institution, given		•		4b. City,	Town, or	Location of	of Death		4c.	County of De		
			SHADY GROVE ADVEN				ROCK						NTGOME	RY	
	Funeral Director		,	Sex 7. A 1 □ M 2 🕅 F		(Ast birthday) (Ast birthday)	If Under Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D AUG • 2	rth ay, Year)	9. B	irthplace (State Country)	or Foreign
			579-46-7706 Usual Residence of Decedent		7	0					AUG. 2	25, 1	933 WA	SHÍNGTO	N, DC
	show		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside C	ity Limits
	Sa-1 s	Director	MARYLAND MONTGOME	RY	SIL	VER SP	RING							1 ☐ Yes	2XNo
	or 2	Dire	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What (Country?	
	s 23a	ral	10313 LESLIE STRE					902			į	U.S.			
	frem free	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Deceden Armed Forces 1 Yes 2 X	?	S. 13.	Was Deced f Yes, spec	lent of Hi rify Cuba	spanic Ori n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	0-	 Race - Ал Black, Wh 		
920	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1 ☐ Yes 2	2⊠ No	Specify:				Specify: WH	ITE	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-1 show disal Examinet must be notified at	Completed	15. Decedent's E			16a. Deced	dent's Usua	Occupa	ation			16b. Ki	ind of Busines	s/Industry	
2	within ene. than '	nple	(Specify only highest grant (S	College (1-4or	5+)	life. I	kind of wor DO NOT us	e retired	luring most)	of Worki	ng			•	
2	be filed within 72 hours after death with the Maryla ital Hygiene. id other than "natural", or frems 23a or 28a-1 show event, it a Marical Examinat must be notified at		17 Esthada Nasa / Cast Middle / and	2		HOMEM	AKER					1	HOME		
anc	ntal F ed ot ed ot	Be	17. Father's Name (First, Middle, Last		7777					r's Name	(First, Middle				
Z	2 should be and Mental is marked (aumatic ev	ဥ	ABRAHAM 19a. Informant's Name/Relationship (LAPKO	F.F.	10h Mailie	a Address	1	LUBA		I Route Numb		ERNER		
Za	od 2 s lith ar 27 is r trau		ALBERT KAUFFMAN/H											<i>zip Code)</i> ND 20902)
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any njury or other traumatic enones.		20a. Method of Disposition			lace of Dispo	sition (Nam	e of		- National Contraction	ate		cation - City o		_
E	Page Hill Sold		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		,	EAN MEI	-	•		7/09	/2004	OT.N1	EY, MAI	RYT.AND	
alti	permit. Pag Department Important: any njury once.		21. Signature / Fun ral Se v ce Licer	nsee (0022										
	82 5 5		Janey.	In / fre	u .	fb	91 RO	CKVI	LLE	PIKE	L DIREC	TLLE	, MD 2	0852	
i			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death line.	. Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Bets	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Aa	re	myoc	1 /	0	(alm)	cti	Ola			Onset and I	Death L
į,	/Medical Examiner		resulting in dealin)	Due to (or a	s a consequ	ience(o):	. 1		, 0					A	
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	nany s a consedu	ience of):	gen	1 0	un	ero	R			yeur	٥
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		Q									V	
Ó	an and rial-tran	Еха	resulting in death) Last	Due to (or as	s a consequ	ence of):									
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d											
<u> </u>	e as t	Med	IF FEMALE:												
Вох	eath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3 🗌	Ectopic pre					2	3d. Date of de	,	·
o	that the de led by the a detached f	yslc	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4□Pregnant a 9□ Unknown	t time of de	ath 5	Other (spe	city)				İ	MOUTH	Day Y	ear
٦	res that i	by Physician/Me	Part II. Other significant conditions of	ontributing to death I	but not resul	Iting in the un	derlying car	use give	n in Part I.		23e. Did t	obacco us	se contribute t	o the cause of de	eath?
rds,	quires n sign		Acute	Parica	eal	die						Yes 2			nknown
Record	aw require s been sig 2 should b	olete									24a. Was	an	24b. Were a	utopsy findings a	ıvailahle
Ä	The lav	Completed					-				autor perfo	rmed2	prior to death?	completion of ca	iuse of
Vital	sician: Th certificate irector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes (Check only o	2 No	1 🗌 Yes	3	
dens.	S S	2	1 ☐ Yes 2 No	Hospital: 1 VInpati	ent 2 E	R/Outpatient	3 🗆 DOA	Other			ne 5 🗆 Resid		Other (Spe	ocify)	
טרכ	ling P	i o	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury ny Year)	28b. Time of Injury		c. Injury Work	at		8d. Describe h				
Division	death death stor: / the /	icat	2 Accident investigation 3 Suicide 6 Could not be		ium. As haa		М		es 2⊡N		±4.1 4	_			
^	lor A after Direction by	Certification;	4 Homicide determined	28e. Place of In building, e	tc. (Specify)	ne, tarm, stre	et, factory,	office		2	City or Tox	Street and vn, State)	Number or R	ural Route Numb	per,
	spita sours neral fillec		29a. Certifier 1 Certifying Ph	ysician: To the best	of my know	/ledge, death	occurred at	t the time	date and	niace a	nd due to the	causo(s) :	and manner as	ctated	
	n 24 h	Medical	(Check only 2 Medical Exaп	niner: On the basis of and manner st	n uxammatii	on and/or inv	estigation, ii	n my opi	nion, deatr	occurre	d at the time,	date and p	place, and due	to the cause(s)	
	To the Hospital or Attending Phywithin 24 hours atter death To the Funeral Director: After th completely filled in by the funeral	Σ	29b. Signature and title of certifier	\bigcap	0-		29c.	License	number			29d. Date	signed (Mont	h, Day, Year)	
•	10		1 preu	aller	-elk	D N	D	35	326	2_		Ju	le 7	2001	4
			30. Name and address of person who	0 2-0 0	4	23а) (Туре, Р	Print)		1 0	/ 1 /12			, 10	holoni	(80
			DK A MENDS 31. Date filed (Month, Day, Year)		1	401 F	esec	MC	15 B	LVV) Suit	03	53 m	5208	50
	Stat Registra	100	JUL 13 201	14 Sens	ar's Signatu	B	Space	Kal	/) Suit				

		For State Registrar 1. Decedent's Name (First, Middle, Las	C	partment of Health and Me Certificate of Death	Reg. Date of Death	0001
Physicia /Medica Examine	al er	RUTH 4a. Facility Name (If not institution, give 1801 E. JEFFERSON	KIRSCHENBAUM street and number) STREET, #404	4b. City, Town, or Location of Death ROCKVILLE	JULY 15	year 8:00 A. 4c. County of Death MONTGOMERY
Funeral Director		5. Social Security Number 6. Sec 099-01-7935 1	7. Age (In yrs. last birtho 7. Age (In yrs. last birtho 94 10c. City, Town o	Y.	Date of Birth (Month, Day, Yelling 1947)	1910 NEW JERSEY
death with the Maryland ms 23e or 28e-f show roughted at	rector	MARYI.AND MONTGOMI 10e. Street and Number			10g.	10d. Inside City Lin 1 X es 2
72 hours after death with neture!; or items 23e or	by Funeral Director	1801 E. JEFFERSON 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced		20852 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Rice 1 Yes 2 No Specify:	U	NITED STATES 14. Race - American Indian, Black, White, etc. Specify: WHITE
d within 72 hours afl giene. er then "neturel", or if e Wickel Exicu	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	acedent's Usual Occupation live kind of work done during most of working e. OO NOT use retired) ###################################	161	O. Kind of Business/Industry OWN HOME
d 2 should be filed th and Mental Hygi i? Is marked other treumatic event, I	To Be Co	17. Father's Name (First, Middle, Last) PHILIP	KRAUT	18. Mother's Name (F		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-1 show eny injury or other treumatic event, If a Marcial Examination is malified at once.	-	19a. Informant's Name/Relationship (T. PHILIP KIRSCHENBAU 20a. Method of Disposition 1 Burial 2 Cremation 3 X 4 Donation 5 Other (Specify) 21. Signature of Funeral Spycice Libers	IM, SON 88 1 20b. Place of Dicemetery, KING DA	sposition (Name of Date crematory or other place)	2004 FA	NNSYLVANIA 18940 Location - City or Town, State LLS CHURCH, VIRGIN
Physician /Medical Examiner	Examiner	show, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. ALZHEIMER S DEMEIT Due to (or as a consequence of): b. VASCULAR DEMENTIAN Due to (or as a consequence of):			Interval Between Onset and Death
ysicië	ical	Cause (Disease or injury that initiated events resulting in death) Last	c			
ysicië	ical	resulting in death) Last	d	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
es that the death certificate be igned by the attending physicis be detached for use as the bu	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	5 Other (specify)	23e. Did tobaco	Month Day Year oo use contribute to the cause of death?
The law requires that the death certificate be ate has been signed by the attending physicis page 2 should be detached for use as the bu	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	d	5 Other (specify)		Month Day Year Do use contribute to the cause of death? The image of the cause of death? The image of the cause of death? The image of the cause of death?
hysicien: The law requires that the death certificate be his certificate has been signed by the attending physicial director, page 2 should be detached for use as the but the but the bound be detached for use as the but th	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	e underlying cause given in Part I. 26. Place of Death (Countries and Doad Other: 4 Nursing Home of 28c. Injury at 28d	1 Yes 24a. Was an autopsy performed 1 Yes 2 X	Month Day Year ouse contribute to the cause of death? 2 \(\overline{\foating No} \) 3 \(\overline{\text{Probably}} \) 4 \(\overline{\text{Unkno}} \) 24b. Were autopsy findings availa prior to completion of cause of death? No 1 \(\overline{\text{YPS}} \) 2 \(\overline{\text{No}} \) 6 \(\overline{\text{Other}} \) (Specify)
Attending Physicien: The law requires that the death certificate be rideath. ector: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the but	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	e underlying cause given in Part I. 26. Place of Death (Countries) 26. Place of Death (Countries) 26. Place of Death (Countries) 27. A Nursing Home of Vork? M 1 Yes 2 No 28. Injury at Vork? M 1 Yes 2 No 28. Street, factory, office 28.	1 Yes 24a. Was an autopsy performed 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month Day Year ouse contribute to the cause of death? 2 \(\overline{\text{Y}}\) No 3 \(\overline{\text{Probably}}\) 4 \(\overline{\text{Unkno}}\) 24b. Were autopsy findings availa prior to completion of cause of death? 1 \(\overline{\text{Y}}\) Yes 2 \(\overline{\text{No}}\) 6 \(\overline{\text{Other}}\) (Specify) njury occurred and Number or Rural Route Number, ate)
Attending Physicien: The law requires that the death certificate be rideath. ector: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the but	ledical Certification; 10 Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	e underlying cause given in Part I. 26. Place of Death (Continuent of the continuent 1 Yes 24a. Was an autopsy performed 1 Yes 2 M Check only one) 5 M Residence 1. Describe how in City or Town, State at the time, date at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, date in autopsy performed to the cause at the time, and the cause at the cause at the cause at the time, and the cause at	Month Day Year to use contribute to the cause of death? 2 No 3 Probably 4 Unknown of cause of death? 24b. Were autopsy findings availate prior to completion of cause of death? No 1 Yes 2 No 6 Other (Specify) njury occurred and Number or Rural Route Number, ate) e(s) and manner as stated. and place, and due to the cause(s)	
itel or Attending Physicien: The law requires that the death certificate be rs after death. rs after death. rel Director: After this certificate has been signed by the attending physicis led in by the funeral director, page 2 should be detached for use as the but	Medical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	26. Place of Death (Continued as a continued at the time, date and place, and rinvestigation, in my opinion, death occurred at the time, date and place, a	24a. Was an autopsy performed 1 Yes 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month Day Year to use contribute to the cause of death? 2 No 3 Probably 4 Unkno 24b. Were autopsy findings availa prior to completion of cause of death? No 1 Yes 2 No 6 Other (Specify) njury occurred and Number or Rural Route Number, ale)

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland		artment of H				ne 2004	23911
	Physici		Decedent's Name (First, Middle,	Last) William	н и1с	in				Date of Death Month July 13	Day Yea	
	/Medio Examir		4a. Facility Name (If not institution,			- 111	4b. City, Town, or	Location of		July 13	2004 4c. County of De	
			Montgomery Ho	spice Case	y House	2	R	lockvi	i11e		Mon	tgomery
	Funeral			i.Sex 7. A 1∭2 M 2 ☐ F	ige (In yrs. las	•	If Under 1 Year Months Days	If Under:	24 Hrs. 8 Min.	. Date of Birth (Month, Day, Yo		irthplace (State or Foreign Country)
	Director		269-09-7382 Usual Residence of Decedent		83	Yrs.			No	ovember 6,		Ohio
	yland yland		10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	a-fs	ctor	Maryland Mon	tgomery			В	ethes	sda			1 ☐ Yes 2 🌠 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g	Citizen of What (Country?
	s 23a			ntbury Dri		1	<u> </u>	2081				d States
40	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or Itams 23a or 28a-f show evant. If a Madical Exarting must be notified at	Funerai	11. Marital Status 1 ☐ Never Married 2 🔀 Married	12. Was Deceden Armed Forces	?	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Orig n, Mexican	gin? (Specit n, Puerto Ric	ly Yes or No- can, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
980	al', or	by	3 Widowed 4 Divorced	1 X Yes 2 If Yes, Give Year or Dates	· WWII		1 ☐ Yes 2 🏋 No	Specify:			Specify:	White
2-0	72 ho	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occupa	ation	t of working	161	o. Kind of Busines	
2	ithin ne.	mpie	Elementary/Secondary (0-12)	College (1-4or	5+)	lite.	DO NOT use retired) -				
5	iled w tygiei thar ti		17. Father's Name (First, Middle, La	5±		S	cientific					nsonian
and	d be fantal h	Be c						io. Mothe	ers Name (r	First, Middle, Mai	,	
ar Z	2 should be filed withir and Mental Hygiene. Is markad othar than aumatic evant, Italia	To	WIII1a: 19a. Informant's Name/Relationship	m F. Klein o (Type, Print)		19b. Mailir	ng Address (Street a	and Numbe	er or Rural P		Urmston	Zip Code)
Ž	alth ar 27 Is 17 Is		Winifred S. Kle	in/ Wife			Kentbury					
ore,	of Hez		20a. Method of Disposition		cem	e of Dispo	sition (Name of	e)	Date	9 200	. Location - City of	
<u><u>ĕ</u></u>	Page ment ment ant: II		1 ☐ Burial 2 🌠 Cremation 3 3 4 ☐ Donation 5 ☐ Other (Spe		Mont Crem	gomen	um Inc.	-/ ·	July 14, 20	004	Bethesda	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 21 is marked any injury or other traumatic at once.		21. Signature of Funeral Service Lic	Seplent	M0033	22	. Name and Address	s of Facility	v Robe	rt A Pi	imphres 1	Funeral Home/ consin Avenue
			23a. Part1. Enter the disease, or ex shock, or heart failure. List or	implications that cause ily one cause on each	ed the death. line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a Li	ver Car	ncer						Onset and Death Weeks
١	/Medical Examiner		resulting in death)	Due to (or a	s a consequer	nce of):						Noons
		5	Sequentially list conditions,	b. Due to lor a	s a consequen	voci mfli						
	uted 3 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury									
o,	an and rial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or a	s a consequer	nce of):						
8760,	icate be executed physician and s the burial-transit	dicai		d								
39	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	0	IF FEMALE:									
Вох	eath certific attending p for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 Fetal de	ath 3	Ectopic pregnancy				23d. Date of de Month	elivery Day Year
ó	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a 9☐ Unknown	at time of deat	n 5L	Other (specify)					- 4,
o, G	res that igned by be deta	y Ph	Part II. Other significant conditions	contributing to death	but not resultir	ng in the ur	nderlying cause give	n in Part I.		23e. Did tobacc	co use contribute i	to the cause of death?
rds	w requires been sign should be	ed by								1 🗌 Yes	2 X No 3□P	Probably 4 Unknown
Record	aw re	Completed								24a. Was an		utopsy findings available
Ĭ.	The lav	mo:								autopsy performed 1 ☐ Yes 2X	Prior to death?	completion of cause of
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death C	check only one		
	or Attanding Phyaician: tter death. Diractor: After this certific in by the funeral director,	2	1 ☐ Yes 2 🛣 No	Hospital: 1 Inpati		/Outpatien		4 L Nui				ecify) Hospice
Division of	ding I	tion	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	a <i>y Year)</i> 28	lb. Time of Injury	28c. Injury Work M 1 □ Y	?		. Describe how in	njury occurred	
18	of or Attandi after death. Diractor: A d in by the fu	ficat	2 Accident investigat 3 Suicide 6 Could not	be on Disease la	niury - At home	a farm stre	eet, factory, office	′es 2⊡N	-	Location (Street	and Number or E	lural Route Number.
2	alor/ after Dira	Certification:	4 ☐ Homicide determine	building, e	tc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	ou, radiory, diffica		2011	City or Town, St	ate)	iora riode runiber,
	Hospital 24 hours a Funeral [tely filled		29a. Certifier 1X Certifying	Physician: To the best	t of my knowle	dge, death	occurred at the time	e, date and	d place, and	due to the cause	e(s) and manner a	s stated.
	To the Hospital within 24 hours a To tha Funeral I completely filled	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner s	of examination tated.	and/or inv	estigation, in my op	inion, deati	h occurred a	at the time, date	and place, and du	e to the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	7			29c. License	number		29d.	Date signed (Mon	th, Day, Year)
10	41		I Chhi	Jenpone				42452			July 1	4, 2004
1-			30. Name and address of person wh				•		07		-	
	Sta	e	Chitra Rajagopa: 31. Date filed (Month, Day, Year)		lll Pri rar's Signature				2/ 01 ₁	ney, Mar	yland 20	835
	Registr		JUL 152		wa	5	Sparks	/				

			1 - For State Registrar	State of	Maryla		artment o			d Mental H	ygien Reg. N		230	12
	Physici	an	Decedent's Name (First, Middle Orville	Junior	Mi	chaels				2. Date of D Month July	Death D	ay Year	3. Time of 8:51	Death
	/Media	al	4a. Facility Name (If not institution			liaeis	4b. City. To	wn.orlo	ocation of De			c. County of De		Рм
	Examin	er	Garrett County	•		tal	Oakla			,		Garrett	uu,	
	Funeral		5. Social Security Number	6. Sex 1. ★ M 2 ☐ F	7. Age (In yr	s. last birthday)	If Under 1 \		f Under 24 H	Irs. 8. Date of E in. (Month, L			irthplace (State o	r Foreign
	Director		218-38-0281 Usual Residence of Decedent	ILAN ZUF	64	Yrs.				Oct. 1	0, 1	020	ryland	
	yiand sow		10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10d. Inside Cit	•
	e-fst	ctor	MD Garı	rett	Fr	iendsv:	ille						1 ☐ Yes	2 1 No
	or 28	Director	10e. Street and Number				10f. Zip Co				10g. C	itizen of What C	Country?	
	eath v	eral	212 Teets Road 11. Marital Status	12. Was Dece	dent Ever in	115 12	Was Doodon		1531	(Specify Vec or)		USA 14. Race - Am	ariana India	
٥	riter d	Funeral	1 ☐ Never Married 2 ☑ Marr	Armed For ied 1 ☐ Yes	ces? 2. ∑ No		_	,		(Specify Yes or Nerto Rican, etc.)	40-	Black, Wh		
9500-6121	filed within 72 hours after death with the Maryland I Hygiene. other then "natural", or Items 23a or 28e-f show fent, I're Medical Exa., it or invat be ricillized.	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da	8		1 □ Yes 212	No S	Specify:			Specify: Wh	ite	
7	"natu	Completed	15. Deceden (Specify only higher			(Give	dent's Usual C kind of work o	done duri		vorking	16b. l	Kind of Busines	s/Industry	
7	filed within 72 Hygiene. other then "nat ent, the Medic	duc	Elementary/Secondary (0-12)	College (1	-4or 5+)	Sawmi	DO NOT use i	etirea)			Т.,	mb a sa		
and	e filed Il Hygid other vent, I	O I	17. Father's Name (First, Middle,	Last)		Sawiii.	rier	18	3. Mother's N	lame (First, Middi		mber n Sumame)		
<u> </u>	should be and Mental s marked c umetic eve	To B	James Michaels					I	Laura	Sines				
Mar	0 0 2 0		19a. Informant's Name/Relations			19b. Mailir	ng Address (S	treet and	Number or	Rural Route Num	ber, City	or Town, State,	Zip Code)	
	is 1 and 3 of Health item 27 other tr		Shirley J. Micha 20a. Method of Disposition	els/Wife	20b.	Place of Dispo	ets Ro	oad,	Frien	dsville,		21531 Location - City o	Town State	
פֿר	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		olate	Place of Dispo			77	2004				
saitimore,	permit. Pages Depurtment of I Importent: If it any injury or o		21. Signature of Funeral Service		58	ind Spr				y 18, mes, P.A	Fri	endsvil	le, MD	
ñ	Per Im B		De Day	Journa	w					ntsville		21536		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	acute a. Due to (o	myoca or as a conse	rdial i	nfarct	ion			arrest,		Approximate Interval Betwoen Sonset and D minu	leath .
•		Examiner	Sequentially list conditions, farry I saw g to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (c	or as a conse		irdiova	scui	ar di	sease			7 year	#
X oo loo,	certificate be executed iding physician and use as the burial-transi	cian/Medical	IF FEMALE:	d. 23c. If yes, outc	come of prear	nancy						004 Date of de		
.O. BOX	death e atter	hys	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bi	nth 2 ∏ Fet antattime of	al death 3	Ectopic pregr Other (specif					23d. Date of de Month		ear
cords, r	requires that the een signed by th nould be detache	ted by P	Part II. Other significant condition diabetes mell		ath but not re	sulting in the ur	nderlying caus	e given ir	n Part I.				o the cause of de robably 4 🛣 Ur	
al nec	n: The law i icate has be r, page 2 sh	Completed								24a. Wa auto perf 1 ☐ Yes	opsy ormed?	prior to death?	utopsy findings a completion of car 2 No	vailable use of
VIII	s certil	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ※ Joo	Hospital:	patient 2	XER/Outpatien	3 DOA	04		eath <i>(Check only</i> Home 5 ☐ Res		S [] () ++ () -+		
	nding Phy th. r: After thi e funeral c	\vdash	27. Manner of Death 1 \(\Delta \) Natural 5 \(\Delta \) Pending 2 \(\Delta \) Accident investig	28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe			спу)	-
DIVIS	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 286. Place	of Injury - At I g, etc. <i>(Sp</i> ec	nome, farm, stre	eet, factory, of	fice		28f. Location City or To			ural Route Numb	er,
	the Hosp hin 24 hou the Funer npletely fill	Aedical	one)	g Physicien: To the la examiner: On the ba and mann	sis of examin	owledge, death ation and/or inv	estigation, in	my opinio	on, death oc	ce, and due to the curred at the time	, date an	d place, and due	to the cause(s)	
	To with	Σ	29b. Signature and title of certifier	Ma		110		cense nu				te signed (Mont		
		-	30. Name and address of person	July sometimes	no dans "	D 236) (T		0257	J9		July	14, 20	104	
		2	Walter K. Nauma					nt Mi	D 2152	20				
I	Sta		31. Date filed (Month, Day, Year)		gistrar's Sign		1 0							
	Registra	ar	AAF	TO POOL	The state of the s	De De	AZZONO NA	P						

			Olalo or mary		tificate of		Mental Hygi	eg. NØ:	11. 2	3013
Physic /Medi		1. Decedent's Name (First, Middle, Las Darius Green Mill					2. Date of Death Month July 10	Day	Year 1:	ime of Death :06 p.m.
Examir		4a. Facility Name (If not institution, given 1878 Blue Lick Ro				4b. Cify, Town, or Lonaconi		4c. County Ga		
Funeral Director		5. Social Security Number 201-07-0969 6. Se	9x 7. Age (In 2 M 2 □ F 8.	n yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Dec 20,	Year) 1922	9. Birthplace Country) Maryla	(State or Foreign
Maryland -f show fed at	tor	Usual Residence of Decedent 10a. State 10b. County MD Garrett	10	c. City, Town or Loc Lonaconi						nside City Limits □ Yes 2 🖾 No
h with the 23a or 28a ist be not	Funeral Director	10e. Street and Number 1878 Blue Lick Ro	pad		10f. Zip Code 2.	1539	10	og. Citizen of V USA	What Country?	
within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examinat must be mailfied at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 🖫 Yes 2 □ No. If Yes, Give Year or Dates:		Vas Decedent of I Yes, specify Cub ☐ Yes 2√2 No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - American Inck, White, etc. white	
within iene. than	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 10 th			ent's Usual Occu kind of work done OO NOT use retire Operator	pation oduring most of wo ed)		Welding	usiness/Industry	′
should be filed and Mental Hygis marked other umatic event, ii	To Be	17. Father's Name (First, Middle, Last) Lloyd L. Mil.ler					me (First, Middle, M M. Green	faiden Suman	16)	
es 1 and 2 should of Health and Mer f item 27 is marke r other traumatic		19a. Informant's Name/Relationship (7 Barbara M. Creekm					ural Route Number, onaconing			
permit. Pages 1: Department of He important: If iter any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cob. Place of Dispos cemetery, crem rantsvill	atory or other pla				City or Town, S	
permit. Departr imports any inj		21. Signature of Funeral Service Licent	Perman	/			mes, P.A.		эх 275 21536	
Physician /Medical Examiner	J.,	23a. Part1. Enter the disease, or comp shock, or hear failur. List only of the composition of the compositio	a. Arterio		vi Covo				Ons	roximate val Between et and Death
executed n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b.	to (0, as a consequ	yerice of).					
certificate be executed ding physician and se as the bunal-transit	edicai	Cause (Disease or injury that initiated events resulting in death) Last	c	to (or as a consequ	rence of):					
requires that the death certif neen signed by the attending hould be detached for use a	Physician/M	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the un	derlying cause gi	iven in Part I.	23b. Did tob	pacco use co	ntribute to the	cause of death?
8 50	<u>م</u>							s 2 No	3 Probably	utopsy findings
aw 2 S	Completed						24a. Was an perform	ied?	available	e prior to ion of cause
Page T	Be Co	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		1 ☐ Yes	2 □ No
Physician: rthis certific rral director,	To B	examiner? 1☐Yes 2☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA Ott	hor:	lome 5 Resider		er (Specify)	
ing Witel		27. Manner of Death 1	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Inju Wo M 1 □	iryat ork?]Yes 2 □ No	28d. Describe how	w injury occuri	red	
ital or Attend its after death al Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	et, factory, office		28f. Location (Str. City or Town,		er or Rural Rou	te Number,
n 24 hours a n 24 hours a ne Funeral D	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my iner: On the basis of exa and manner stated.	mination and/or inve	occurred at the ti estigation, in my o	ime, date and place opinion, death occu	e, and due to the car arred at the time, da	use(s) and ma te and place,	inner as stated. and due to the o	cause(s)
To the within 2 To the complex	M	29b. Signature and title of certifier	20-	CC.	29c. Licens	se number	29	d. Date signe	d (Month, Day,	Year)
Verit CO CO		//// \9	14.1/1	13	1.1	/ /		/ /	/ CLE	
£ 3 £ 8		3U. Name and address of person who co	ompleted cause of death	(Item 23a) (Type, F	H Z	(e150	ikmel,	1/12	104	

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMENDED 26,7/14/04, LDB, DOR Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2004 Year 5, Jüly Barbara Ann Miller 10:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Dealh Examiner Talbot 5690 Roya 1 0ak Gate Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕅 E 52 Director 579-52-2538 16,1952 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ar than "natural", or Items 23a or 28e-f show the Madical Examiner must be notified at 1⊠Yes 2 No MD Director Hyattsville Prince George's 10e. Street and Number 10g. Citizen of What Country? 20784 5456 United States Madison Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black ğ 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Recreational Assistant 12th Private Pages 1 and 2 should be filed vent of Health and Mental Hygie ent; if Item 27 is marked other? other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Shirley E. Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Lewis - Son 2753 Sacramento Ave. Pittsburgh, PA 15204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of the Importent: If Ite any injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State 7/14/2004 Suitland, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Ceme. 22. Name and Address of Facility Henry Funeral 21. Signature of Funeral Service Licenses Home, PA 510 Washington St., Cambridge, MD 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascule Obsease Physician Arteriosclerati disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy performed? certificate 1 Yes 2 No Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cousin's Hospital: Other: 4 Nursing Home 5 Residence 6 QOther (Specify) P 11X Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral din this residence 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide ŏ 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical the title of certifier 29b. Signature an 29c. License number 100 44282 and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar provski, mo

32. Registrar's Signature

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(laude

31. Date filed (Month, Day, Year)

4410 Buchelons Pt. Rd. Oxpurs, ma 21654

		-	For State Registrar	State of Maryland /		rtment tificate					nnı	23915
	Dhuaiais		Decedent's Name (First, Middle, Last)						July 1			3. Time of Death 8:55 P. M
	Physicia /Medic	al		RTIN		41 O'S 7	F	ocation of Dea			County of Deet	
/	Examin	er	4a. Facility Name (If not institution, give str Washington Advent	ist Hospital		Takom			iu)		tgomer	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last 65	birthday) Yrs.	If Under 1	1 Year Days	If Under 24 Hr Hours Mir		th 1938	9. Birti	nplece (State or Foreign CAT) Carolina
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To								10d. Inside City Limits
	Maryll -f eho	tor	MD Prince Geor	rges Capit	al H	leight	S					1⊈Yes 2 □No
	h with the 3a or 28e	ai Director	10e. Street and Number 6304 Liberia Street	-		10f. Zip	Code 20743	3			en of What Co U.S.A.	untry?
ဖွ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "nature!", or Iteme 23a or 28e-f show sumatic event, the Medical Examinar is ust be notified at	/ Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Was Decede f Yes, spec 1 ☐ Yes 2		panic Origin? (, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)		4. Race - Ame Black, White Specify: Bla	e, etc.
Ö	hours tural',	ed by	3 ☐ Widowed 4 ፟፟ Divorced 15. Decedent's Education	Year or Dates:		dent's Usua	•	tion		16b. Kin	d of Business/	Industry
1215-	within 72 ene. than "nai	Completed	(Specify only highest grade	College (1-4or 5+)	(Give	kind of wor DO NOT us	k done du	uring most of w	orking		nstruct	
Baltimore, Maryland 21215-0036	should be filed wi and Mental Hygien s marked other th numatic event, the	To Be Co	17. Father's Name (First, Middle, Last) Lawrence Martin	n					ame <i>(First, Middl</i> e t ti e McEa			
Mary	od 2 shou th and M 27 is mar r traumat		19a. Informant's Name/Relationship (<i>Typ</i> Ada Hunter / sist						Rural Route Numb			Zip Code)
nore,	ages t are ont of Hear you other		20a. Method of Disposition 1	moval from State Shi	of Dispo etery, crer loh (sition (Nam natory or of Cemet 6	ne of ther place E ry	Jul	y 10,2004		Paul,	
Baltir	permit. Pages t and 2 should by Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic evonce.		21. Signature of Fundal Served Licenser	Bula					orchinsky NW Washir			
	Physician	0	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	e cause an each line.						rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a consequen	ice of):	- P1	NEU	1 G MON7	A			5DAYS
,760,	eath certificate be executed attending physicien and for use as the burial-transit	cal Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen								
P.O. Box 68	the d	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 12 No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3	Ectopic pr				2	3d. Date of de Month	livery Day Year
	uires that the signed by	d by Pr	Part II. Dther significant conditions cont — BILATERAL LUM	1 . (in the u		ause give			tobacco us	1	o the cause of death?
Vital Records,	The law requires that ate has been signed b page 2 should be deta	mplete	DISOLDER, CERENTA	WINE TO THE		IT, N	TALL	UTIZI DO	- arutt	ormed?	24b. Were an prior to death?	utopsy findings available completion of cause of
ta		a	25. Was case referred to medical	will to him.				26. Place of C	Death (Check only		12,00	
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ion o	ath. or: Afte		27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	Bb. Time o Injury	of A	28c. Injury Work 1 🗆 `	rat k? Yes 2 □ No	28d. Describe			
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, st	reet, factory	y, office			(Street and own, State)		urai Route Number,
	e Hospi 124 hou e Funer letely fill	ledical	29a. Certifier Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my knowle ler: On the basis of examination and manner stated.	edge, dea n and/or ir	th occurred nvestigation	at the time to my or	ne, date and pla pinion, death o	ace, and due to the courred at the time	cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
	To the To the complex	Me	29b. Signature and title of certifier	lundar		290	c. License	3367		_	e signed (Mon.	th, Day, Year) JD 2004
			30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type 5//	Print) 5	2,	GAITHE	LSUVAL,		2087	3
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	9	do	uks	/				

DHMH 17 Rev 1/2001

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					State of M	aryland /				mental Hy			
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г	Physici	ian	1. Decedent's Nam	-						Month July	Day	Year	0245
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Ī	Funeral Director		Social Security N	DEERS HEAD HOSPITE CENTER SALISBUT. Social Security Number 212-16-7158 6. Sex. 7. Age (In yrs. last birthday) H Under 1 Year H Under 24 Hrs. 8. Decided by the security Number N								9. Birthplace Country Mary La	(State or Foreign nd
	· ·		Usuel Residence of			140 - Cit - T						104 -	oido City Liveita
7	show	5	In the state of th								10d. Inside City Limits 1 ☐ Yes 220No		
7	the N	ect	Maryland Dorchester Hurlock 108. Street and Number 101. Zip Code								10g. Citizen of	What Country?	
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0	deeth	nera	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U,S.	13. W	as Decedent of I	Hispanic Origin? (an, Mexican, Puer	Specify Yes or No	- 14. Rac	ace - American Indian, lack, White, etc.	
020	filed within 72 hours after deeth with the Meryland Hygiene. ther than "naturel", or items 23a or 28e-f show thit, the Medical Examiner must be notilied at	by Funeral Director		1 Never Married 2 Married 1 Yes 2 N I Yes, Give Year or Dates:				Tes, specify Cub		no ribari, oto.,	Specify		
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e.	- I = =		20a. Method of Dis	position		20h Place (of Disposit	tion (Name of atory or other pla	ce)	Date	20c. Location -	City or Town, S	itate
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Baltimore,	permit. Depertrimporty any Info		21. Signature of Fu	1 1/2		mu	10	Name and Addre		meral Ho	ome, P.A		
			23a Part1 Enter t	he disease, or co	mplications that caused y one cause on each li	the death. Do	not enter	the mode of dyi	ng, such as cardia	oridge, loc or respiratory a	1D 2161 rrest,	Appr	oximate val Between
nag.	Physician		snock, or nea	n tallune. List onl	y one cause on each ii	ne.						Onse	et and Death
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л Э	the d	nysi			contributing to death b				ven in Part I.		23b. Did tobacco use contribute to the cause of death		
<u>, 8</u>	v requires thet the deeth certi been signed by the ettending should be deteched for use a	by Pi			E HEAR			URE			, .		
Kecords,	The law requires thet the deeth certificete be executed the been signed by the ettending physician end page 2 should be deteched for use as the bunel-trensit	Completed by Physician/M	ATRI	ALF	(BR(L	LATIC	N				an autopsy rmed?	available	stopsy findings o prior to ion of cause ?
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0	nysician: The la nis certificete hes I director, page 2	To	examiner? 1 ☐ Yes 2.2	No	Hospital:	ent 2 ER/O	utpatient	3LI DON		Home 5 ☐ Resi	dence 6 □Oth	er (Specify)	
	Attending Physician: or death. ector: After this certific by the funeral director,		27. Manner of Deet 1 Natural	5 Pending	28a. Date of Inju (Month, De	y Year) 28b.	Time of Injury	28c. Injui		28d. Describe	how injury occur	red	
UNISION	ttendi death :tor: /	icat	2 ☐ Accident 3 ☐ Suicide	investigati 6 ☐ Could not	be 29a Blace of Ini	uor - At home f	arm stree		Yes 2□No	28f. Location (Street and Numb	er or Rural Rou	te Number.
<u>></u>	7 4 4 C	Certification:	4 Homicide	determine	building, et	c. (Specify)	am, 3000	n, lactory, critico		City or To			
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifier (Check only one)	1⊠ Certifying P 2 Medical Exa	hysician: To the best of the basis of and manner sta	examination ar	e, death o	occurred at the tir stigation, in my o	me, date and place opinion, death occi	e, and due to the urred et the time,	cause(s) and ma date and place,	anner as stated. and due to the o	ause(s)
	o the	M	29b. Signature and		^			29c. Licens			29d. Date signe		
			Vna	A nu	Dulary	My en		J 3	3905		July 9	,200	4
			30. Neme and addr	ess of person who	completed cause of d	leath (Item 23a) O CMD	(Type, Pr	Boy ZO	18 54	LISBUR	y md	, 2180	2-2018
4	Sta Registr	ate rar	31. Date filed (Mon	th JOYL Year) 4	completed cause of d	er's Signature	So	cule					
	ricgisti	-11			1,00	-A-1	1	- consti					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1110 2004 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MEMORIAL HUSPITM TALBUT if Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days Hours 220-01-1418 Yrs. July 07.1 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No Talbot chae Funeral Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ark , ane 6 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 12 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 21 No Specify: Completed by 3 Widowed 4 □ Divorced Black "naturel" 7 is marked other than "natur treumatic avent, the Modest 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Residence Farmer R. Vate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sharp NORMAN abor (UnKnown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CORNERRD.C 27 eatherbe ordova, MD. James 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location City or Town, State 20a. Method of Disposition Department of I important: If its any injury or o one. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Pleasant Cometery 9/04 Reston 4 □ Donation 5 □ Other (Specify) 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate

Immediate Cause (Final) Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner bshuctive disease 0 Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 1 🗌 Yes 2 🗆 No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Wasan cate has l autopsy 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be

Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, Director: / within 24 hours at To the Funerel D completely filled i To the

William

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lakshmi Vaidyanathan, M.D., 219 S. Washington St., Easton, MD

State Registrar

Medicai

				State of Maryland	/ Departi		ealth and M	•	_	23918		
	Physici		1. Decedent's Name (First, Middle, Last) Beatrice Ann Shupe					2. Date of De Month July				
	/Medio Examin		4a. Facility Name (If not institution, give st		41	o. City, Town, or I	ocation of Death	July	4c. County of D	<u> </u>		
	LXaiiiii		Talbot Hospice Hou	se		Easton			Talbot			
	Funeral Director		219-32-4867	7. Age (In yrs. lat		Under 1 Year onths Days	Hours Min.	8. Date of Bi (Month, D. Oct. 1	1, 1936 N	Birthplace (State or Foreign Country) Pary Land		
١	Maryland I-f show	'n	Usual Residence of Decedent 10a. State 10b. County MD Talbot		Town or Location	on				10d. Inside City Limits 1 Yes 2 □ No		
\$	with the N a or 28a-f	rect	10e. Street and Number	Eas	ston	Of. Zip Code			10g. Citizen of Wha	t Country?		
8	h with	al Di	640 Mecklenburg Av	e.		21601			USA			
36 ×	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other then "neturel", or items 23s or 28s-f show other treumatic event. Ire Mcdical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Morried	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		Decedent of His s, specify Cuban Yes 2 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black, V	American Indian, Vhite, etc. Vhite		
Baltimore, Maryland 21215-0036	within 72 hours a ene. then "naturel", o	pleted	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	(Give kind life. DO		tion uring most of work	ing	16b. Kind of Busine	ess/Industry		
2	filed wil Hygien ather th	Con	12		Secre		40 14-15-1 11	//**	Governm	ient		
and	I be fill hital Hital Hital Hital Hital	Be	17. Father's Name (First, Middle, Last) Albert J. Droll				18. Mother's Nam Yarmila		, Maiden Sumame)			
17	should nd Men marke umatic	၉	19a. Informant's Name/Relationship (Typ	ee, Print)	19b. Mailing A	ddress (Street ar			er, City or Town, Sta	te, Zip Code)		
≥ S	alth ar 27 is or treu		Larry Steven Phelp		9118 B	ryant Av	e., Laur	el, MD	20723			
nore,	permit. Pages 1 and 2 s Department of Health ar Importent: if Item 27 is any injury or other treu <u>once.</u>		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Re	emoval from State	-	ory or other place		Date 2 / 2 / 0 / / /	20c. Location - City Cambride			
ij	artme ortent injury		* 4 □ Donation 5 □ Other (Specify) 21. Signardre of Funeral Se(viet) License						Home, P.A.	, ,		
ä	Der Per		Volsteen Herr	es-Benus								
	Physician		Z3a. Pad Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ration hat caused the death.	Do not enter th	ne mode of dying	such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death		
	/Medical Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter this arithmic Cause (Disease or injury	Due to (or as a conseque								
760,	e be executed sician and e burial-transit	cal Examiner	resulting in death) Last Due to (or as a consequence of):									
. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	delivery Day Year								
ds, P.O.	uires that the d signed by the Id be detached	þ	Part II. Other significant conditions con	1	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
Recor	The law require ate has been si page 2 should I	Completed						24a. Was auto perf 1 \(\text{Yes}	psy prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No		
ital	iclen: Th certificate ector, pag	a	25. Was case referred to medical				26. Place of Deat			163 20110		
Division of Vital Records,	ng Phys fter this	tion; To B	examiner? 1 Yes 2 No Hi 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	Othe 28c. Injury Work M 1 TY	at		dence 6 Other (S	Specify) HOW ICE nouse		
Divisi	el or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street,	factory, office			Street and Number o wn, State)	r Rural Route Number,		
	To the Hospitel or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical O	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death oc on and/or invest	curred at the time igation, in my op	e, date and place, inion, death occur	and due to the red at the time	cause(s) and manne date and place, and	r as stated. due to the cause(s)		
	To the within To the comp	W	29b. Signatury and title of certifier Multiple 10 of certifier Multi	M		29c. License	number 9887		29d. Date signed M	onth, Day, Year)		
			30. Name and address of person who con				MD 04.60	.1	1			
	Sta	ato	Dr. David Smith 31. Date filed (Month, Day, Year) 1 4	29466 Pintail	Drive,	Easton,	MD 2160	<u>π</u>				
	Regist		JUL 14	2004. Registar's Signatu	J. A.	posts						

			1_ For	State of Maryl		artment of		_	giene Reg. No. 2 0 0 4	23010		
-	hysici	an	1. Decedent's Name (First, Middle, Last)			inioate of	Douth	2. Date of De. Month	ath Day Year			
is:	/Medic	al	Shelton Warren S 4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of De	June	4c. County of De	9 11		
	uneral rector		7777 Fairplay Ros 5. Social Security Number 6. Sex 212–58–9818		yrs. last birthday) 52 Yrs.	Boonsb If Under 1 Year Months Days	If Under 24 H		th y, Year) 9. B	con County inhplace (State or Foreign County) aryland		
Maryland	maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washingt		:. City, Town or Lo					10d. Inside City Limits 1 🗆 Yes 2 📉 No		
with the	a or 28a	Direc	10e. Street and Number 7777 Fairplay Road			10f. Zip Code 217	12		10g. Citizen of What (Country?		
1 213-0036 within 72 hours after death with the Maryland ene.	at', or items 23 Xeminer must	by Funeral Director		12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 14. Race - An Black, Wh	nerican Indian, hite, etc. White			
215-0 (thin 72 hou 9.	An "nature	Completed by	15. Decedent's Educing (Specify only highest grade		(Give		ed) ed)	vorking	16b. Kind of Busines			
d 21.	other th	Be Corr	12 17. Father's Name (First, Middle, Last)		P	ipe Fitt		ame (First, Middle,	Sprinkle	er Company INK		
Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mental Hygiene.	1 and 2 should be 4ealth and Mental 8m 27 is marked o ther traumatic eve	ToB	Tay Warren Smith 19a Informant's Name/Relationship (Ty) Gisele Lynne Smit			,			er, City or Town, State, Maryland 2			
Baltimore, I bermit. Pages 1 and Department of Healt			20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)				20c. Location - City or Town, State Hagerstown Maryland				
Baltimor	Importan any injur once.		21. Signature of Funeral Service License		2:	2. Name and Addr	ress of Facility D	ouglas A.	Fiery Fur			
/M	sician edical miner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	death. Do not en	ter the mode of dy				Approximate Interval Between Onset and Death		
760, te be executed		cal Examiner	Sequentially list conditions, the sequentially list conditions, the sequential cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of):								
ords, P.O. Box 687 requires that the death certificate	ed by the attending physician and detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month						lelivery Day Year		
ds, P.	9	by	Part II. Other significant contained in containing to death but not resulting in the discentifying datase growth in tart.									
I Rec	cate has been si , page 2 should l	Completed						24a. Was autop perfo 1 Yes	ormed?// prior to	autopsy findings available o completion of cause of 2 s 2 \sum No		
	this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	2 EP/Outpatie	nt 3 DOA		eath (Check only of Home 5 Resid	one) dence 6 □Other (Sp	pecify)		
Division of lor Attending Phy after death.	r: After th ie funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	f 28c. Inju			how injury occurred			
Division or he Hospital or Attending Pho 24 hours after death.	To the Funeral Directo completely filled in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)		reet, factory, office		28f. Location (S City or Tox	Street and Number or a wn, State)	Rural Route Number,		
Hospi 24 hou	Funer etely fill	Medical		sicien: To the best of my ner: On the basis of exa- and manner stated.								
To the within 2	To the	Me	29b. Signature and title of certifier	10		29c. Licer	nse number		29d. Date signed (Mo.	**		
, v	16		30. Name and address of person who co	mpleted cause of death		Print)	4166	7	7.1.	· 7		
DHY.			Michael Ma	Corneck	11110	nedical	Comp	· H,	Jer, Lun	NO		
	Sta Registi		31. Date filed (Month Jur. Year) 2 2()04 Seem	Signature J.	serles						

			1- Registrar Amend Item 18 United Prof Man 234, 27 28 and 1- Registrar Amend Item 1 per me G836 Certific	ent թ <u>ե</u> Healthongs Խ ate of Death106	lgnig j⊥ ly gie -04 tas _{Rag.} ı	2004	23920		
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Logan Swigerd Logan Michael Swigert Logan Michael Swigert		2. Date of Death JULY 21,	^{Day} 2004 Year	3. Time of Death 9:03 P м		
	Examir		4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND PICU	City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	1		
Š	Funeral Director		220-67-0207 112 Yrs. Mont	nder 1 Year If Under 24 Hrs. ths Days Hours Min. 21 9 3	8. Date of Birth Month Day Ye. 10/31/20	9. Birthp Coun Caro	olace (State or Foreign ntry) line		
_	death with the Maryland ms 23a or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City Town or Loca			10d. Inside City 1 XYes 2			
	th with the 23a or 28a	Funeral Director		. Zip Code 21629		10g. Citizen of What Country? USA			
980	n 72 hours after dea "natural", or Items adical Examinan	by	1/2 Never Married 2 Married 1 Yes 2/7 No	ecedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto as 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.		
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) infai	Kind of Business/Inc	•				
yland 2	2 should be filed within 72 and Mental Hygiene. Is marked other than "nai aumatic event, the Medic	To Be C	17. Father's Name (First, Middle, Last) Michael Wallace Swigert	Nicole		Toulson			
	permit. Pages 1 and 2 should by Department of Health and Menia Important: If item 27 is marked any injury or other traumatic a <u>once</u> .		Michael W. Swigert/father 406 No. 20a. Method of Disposition (20b. Place of Disposition (20b. Place of Disposition) (20b. Place of Disposition	or other place)	t., Apt.	B, Dento	n,Md21629		
Baltimore,	permit. Page Department Important: II any injury or		'4 □ Donation 5 □ Other (Specify) Capitol Cr	rematory 7/25 and Address of Facility ce Funeral Ho					
68760,	ificate be executed Sphysician and as the burial-transit	edicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the new shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Interval Between Onset and Death		
P.O. Box 68	the death certifica y the attending ph iched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c pregnancy (specify)		23d. Date of deliver Month	ry Day Year		
	w requires that the der been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlyin	ig cause given in Part I.		use contribute to the	e cause of death?		
Vital Records,	iician: The law requ certificate has been rector, page 2 should	Completed			24a. Was an autopsy performed?	prior to com death?	osy findings available apletion of cause of		
Division of Vit	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death within 24 hours after death. To the Luneat Director After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Certification; To Be	25. Was case referred to medical examiner? 1 X fes 2 No 27. Manner of Death 1 Natural 2 X Accident 3 Suicide 4 Homicide 1 X Inpatient 2 ER/Outpatient 3 Telephone 28a. Date of Injury 4 Sevent Several Pound 28b. Time of 6: 157 Found 28b. Place of Injury - At home, farm, street, fact building, etc. (Specify)	28c. Injury at Work? 1 Tyes 2 Tho	ne 5 Residence 28d. Describe how in	apped in land, Number of Rural to 406 N. 6	blanket on		
	Ne Hospite 24 hours ne Funera sletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurr 2 XMedicel Examiner: On the basis of examination and/or investigation and manner stated.	red at the time, date and place a	and due to the causel	s) and manner as sta	ited. the cause(s)		
	To the To the Comp	Me	Jasker ? Greenbey NO	O C M ED583	04 29d. D	JULY 22,			
			Jac ~ Grangery 1718	111 Penn Street	, Baltimo	re, Maryla	ind 21201		
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 6 2004						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 3 Day 2004 Year July **Physician** Emma Evelene Wilt 11:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Moran Manor Nursing Home Westernport Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 88 216-22-7209 **Director** Sep 10,1915 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show s 23a or 28a-f shows the second secon 1 Yes 2 No Director MD Swanton Garrett 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2675 Savage River Road United States 21561 ir than "natural", or items the Medical Exercities "18 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Home Unknown Homemaker permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: If Item 27 is marked other any injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Sweitzer Homa Bowser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Ward/Friend 17242 Maryland Hwy,Swanton,Md 21561 Baltimore, 20b. Place of Disposition (Name of cornetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 7/16/04 Westernport, Md Philos Cemetery 22. Name and Address of Facility Boal Funeral Ho Westernport, Md 21. Signature of Funeral Service Licenses le F 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years an cer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Cheease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ obstructive 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate 2 **X**No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1to 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funerel Director: , completely filled in by the f Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg Plaza, Jesus Tan, Frostburg, Md 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 15 JUL Registrar

		1 - State Amend Item	State of M #2 per d	larylar vr G {	nd / Depa 333 7/2	artme	nt of H	ealth a D <i>eath</i>	ind Me	ental Hyg F	giene 	2	3922
		1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	th 7/9/200	4 3	. Time of Death
Physic /Medi		Charles Jame	s Wal	ters						July 9	, 19 04		2:30 PMM
Exami		4a. Facility Name (If not institution, give	street and number	')		4b. City	, Town, or	Location of	f Death		4c. County of D	eath	
		2073 Friendsvill	e Road					dsvill			Ga	rrett	t
Funeral Director		5. Social Security Number 6. Se 104-01-5508	7. A	ge (In yrs. 87	last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day March	, Year) 30, 1917	Birthplace Country) New	e (State or Foreigi Jersey
pu &		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	cation						10d	Inside City Limits
sho	5											1 ☐ Yes 2 🎇 No	
he M	ect	10e. Street and Number	LL		FILE		ip Code				10g. Citizen of What		
with a sor :	គ	2073 Friendsville	Pond			101. 2		1531			US2		
eath	eral	11. Marital Status	12. Was Deceden	t Ever in U	IS 13 1	Was Doc			in? (Spec	rify Ves or No-			Indian
Lat y failed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or itams 23a or 28e-f show aumatic event, the Madical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	?] No		f Yes, sp		n, Mexican, Specify:	Puerto R	cify Yes or No- lican, etc.)	Black, W Specify:	Black, White, etc.	
P P P P P P P P P P P P P P P P P P P		15. Decedent's Ed			16a. Deced	dent's Us	ual Occupa	ation			16b. Kind of Busine	ss/indust	ITV
1 Se 1	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed)	. 5.1	(Give	kind of w DO NOT	ork done d use retired	during most)	of workin	g			
Z I Z I D-UUSO ad within 72 hours atl gjene. er then "natural", or er the Madical Exami	E	Elementary/Secondary (0-12)	College (1-4or 1	5+)	Senato	rial	Cla:	ims Ex	kamin	er	Social Se	ecuit	y Adm.
Hyginal Hyginal	BeC	17. Father's Name (First, Middle, Last)			'			18. Mother	r's Name	(First, Middle,	Maiden Sumame)		-
Mal y allo d 2 should be file lith and Mental Hy 27 is marked oth traumatic event	To B	James Francis		ers,					nna		zabeth		Lters
i e, Inda yld s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (7) James F. Walters,		har		•	•				r, City or Town, State Alabama	e, <i>Zip C</i> oo 357	
Heal Heal	1	20a. Method of Disposition	II, DIOC	20b. F	Place of Dispo	sition (Na	ame of	200000		ite	20c. Location - City		
ages ant of t: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		9	cemetery, cren Omega (_		· 1	7/10/	'04	Morgantow	2 1.77	
Dallillore, permit. Pages 1 a Department of Hee Important: If item any injury or othe		21. Signature of Funeral Service						s of Facility			Funeral Ho		V
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		Busher	Lard						0.0		, Maryland		550
Physician /Medical Examiner		23a. Part1. Enter the disease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stage, Congestive Heart Failure End Stage, Congestive Heart Failure Years											
death certificate be executed eathending physician and dor use as the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Closease or injury that initiated events resulting in death) Last	b. Due to (or a c. Due to (or a d.										
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Invision of vital necolus, F.O. I or Attending Physicien: The law requires that the after death. Director: After this certificate has been signed by the funeral director, page 2 should be detach.	Completed									24a. Was a autops perfor	sy prior	7	findings available tion of cause of
vicien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Ptace	of Death	(Check only or			
Physicien: This certific ral director,	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat		ER/Outpatien	it 3 🗆 🗅	OA Othe	er: 4 □ Nur:	sing Hom	e 5 Resid	ence 6 Other (S	pecity	25 PLOT
ing Pt		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Inj (Month, D	jury a <i>y Year)</i>	28b. Time of Injury		28c. Injury Work	ι?		8d. Describe h	ow injury occurred		
or Attending fler death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	njury - At h etc. (Specil	ome, farm, str	M eet, facto		Yes 2 □ N	-	8f. Location (S City or Tow	treet and Number or n, State)	Rural Ro	ute Number,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier SCertifying Ph	ysician: To the bes	t of my kno	owledge, death	n occurre	d at the tim	e, date and	f place, ar	nd due to the c	ause(s) and manner late and place, and c	as stated	i.
To the H within 24 To the Fi complete	ledical	one)	and manner s										
With To I	Σ	29b. Signature and title of certifier				29	c. License	number		2	9d. Date signed (Mo		Year)
			(~)~	-			Ι	15333	3	E	7/10	/04	
		30. Name and address of person who	•	-									
		Dr. Thomas Johnso			. Fourt	h St	., 0	kland	l, Ma	ryland	21550		
St Regist	ate rar	31. Date filed (Month Day, Year) 2. 2	.004 32. Regis	trar's Signa	ature	Consti	2						

		Unpend item 1 - State Registrer	State of Marytan		attillefi etificate			nd Me		giene	100	23023
Physic		Decedent's Name (First, Middle, Last, THOMAS ANT)					*	2	2. Date of De Month	eath Day	Year	3. Time of Death 0447 a M
/Medi Examii		4a. Facility Name (If not institution, give Harford Memorial H	street and number)		4b. City, Town, or Location of Death Havre de Grace					y 27, 2004 4c. County of Death Harford		
Funeral Director		5. Social Security Number 293-50-0338 & Security Number 293-50-0338	7. Age (In yrs. 48	ast birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	B. Date of Bir (Month, Da 9/26/	th ay, Year) 55		nplace (State or Foreign untry) VTON, OH
Maryland a-f show	ctor	10a. State 10b. County OHIO STARK		, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2√No
ath with the 23a or 28 unt be ro	ral Dire	10e. Street and Number 1925 38TH STREET		10f. Zip	44	705				. Citizen of What Country? USA		
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Exercites must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed XX Divorced		B. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes XX No Specify:						14. Race - American Indian, Black, White, etc. Specify: WHITE		
ed within 72 hours afgiene. er then "naturel", or et the Medical Exerti	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give life.	dent's Usua kind of wor DO NOT us NSTRU(k done d e retired	uring most					
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and 2 should ba file alth and Mental Hy 27 is marked oth or treumatic event	-	19a. Informant's Name/Relationship (7) VICKII NEWNHAM	rpe, Print)		•						Town, State, Z	
permit. Pages 1 and Department of Healt Importent: If Item 2 eny injury or other once.		20a. Method of Disposition XX Burial 2 □ Cremation 3XXF 4 □ Donation 5 □ Other (Specify)	Removal from State	lace of Dispo emetery, crer REST H	matory`or ot	ther place		Da			cation - City or	
permit. Departm Importe eny inju		21. Signature of Funeral Service Licens RELLY OREGORY	1.1		2. Name and			I IIV			HOME, P	
Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions									Interval Between Onset and Death	
certificate ba executad hairs physician and use as the buriat-transit												
death e atter	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)							23d. Date of deli Month			very Day Year
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The law ate has b page 2 s	Completed										24b. Were au prior to death? 1 2 Yes	topsy findings available ompletion of cause of
Phys r this ral di	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 I	28b. Time of			er: 4□ Nui	rsing Home	Death (Check only one) g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
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To the within 2 To the Complete	M	29b. Signature and title of certifier	29c. License number OCME						29d. Date signed (Month, Day, Year) July 27, 2004			
		30. Name and address of prison who can address of prison who can be seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen as a seen and address of prison who can be seen as a seen and address of prison who can be seen as a seen a	hall mo			l Pe	nn St	reet,	Balt:	imore	, Maryl	and 21201
St	ate	31. Date filed (Month, Day, Year)	32. Begistrar's Signa	ture	,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Voor *Physician Z:02 PM AGNES R. ALLEN 2004 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Button No. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Good Samon ton Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 20XF Months 175-20-1738 2/17/1921 83 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show Itam 27 is marked other than "natural", or items 23s or 28a-f shov other traumatic event, the Modical Examinal must be notified at 1 □Yes 2/□No MARTINSBURG BERKELEY Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25401 USA 255 EAST ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
HOMEMAKER 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental ANNA FETSKO MICHAEL KULBACK ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health 440 TABLER STATION RD., GERRARDSTOWN, WV 25420 KENNY ALLEN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition JULY tXXBurial 2 ☐ Cremation 3 ☐ Removal from State MARTINSBURG, WV Department of Important: If any injury or once. ROSEDALE CEMETERY * 4 ☐ Donation 5 ☐ Other (Specify) 26, 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME P.O. BOX 821 327 W. KING ST., MARTINSBURG, WV 2541)2 acles In XIIaur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Censis Peritonitis
Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Bowel Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine sician and s burial-transit certificate be executed shemic. Due to (or as a consequence of attending physician by Physician/Medical as the IF FEMALE nse s 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dabete autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 **X**No Hospital: Other: 4 Nursing Home 1 Inpatient P 1 Tyes 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After 5 Pending investigation after death.

I Diractor: Afr
d in by the fur 1 ☐ Yes 2 ☐ No 2 🗌 Accident 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier of person who completed cause of death (Item 23a) (Type, Print) 0 addres och Raven Blud, Baltimore, MD 21239 Walker 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 9 2004 Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Regis ar's Signature

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ASKERVIL Day Month y Physician MILDRED 2001 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL NAW DAUSTOWN VORTHWEST Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** -22-764 1 ☐ M 2 👿 F Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23s or 28s-1 show or other traumstic event, the Mudical Examinar must be notified at 1 Nes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number er in U.S. origin? (Specify Yes or No-kican, Puerto Rican, etc.) American Indian, 11. Marital Status Black, White, etc. 1 | Never Married 2 | Married ☐Yes 217 No fYes, Give fear or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ğ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n College (1-4or 5#) ondary (0-12) istadion 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Addr. ss (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any injury or other trau erville (Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Method of Disposition 1 Burial 2 Cremation 3 Removal from State attimore * 4 ☐ Donation 5 ☐ Other (Specify) Greene Funeral Six 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 ☑No 3 ☐ Probably 1 ☐ Yes 4 Unknown this certificate has been sail director, page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of eause of death?

1 ☐ Yes 2 ☐ No 2PINO 1 Yes of Vital 25. Was case referred to medical examiner?
1 ☐ Yes ☐ No 26. Place of Death (Check only one) Medical Certification; To Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

ORIGINAL

NHC

32. Restrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 2:06 1 DOUGLAS SIRA
4a. Facility Name (Mnot institution, give street and number) 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimor . MD If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days **Funeral** 1 X M 2 □ F NJ. 9400 156-22-Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other then "naturel", or items 23a or 28e-1 show treumatic event, the Medical Examinant tre motified at 1 ☐ Yes X☐ No New) 0 Director Adams the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17350 6 Matthew USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Automobile Sales Sales Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy Ames Harry F. Bird 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 I 6 Matthew Drive New Oxford, PA Ann L. Bird/Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages to Department of Hamportent: if Ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cremation Society of Pennsylvania 8/2/04 Harrisburg, PA `4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility

Cremation Society of Pennsylvania Edward A. Gregorchik 17109 4100 Jonestown Road Harrisburg, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): for use as the burial-transit Due to (or as a consequence of): 68760, attending physician Physician/Medicai Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 | Yes 2 | No 3 | Probably 4 Wonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 2 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) this ospitel or Attending Phys hours after death. ineral Director: After this y filled in by the funeral di 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 5 Pending investigation 1 Natural 2 Accident 1 TYes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier. 0 159 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AI

Registrar DHMH 17 Rev 1/2001

State

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31. Date liled (Month, Day, Year)

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JUL 2 9 2004

MSG

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** POLUE 6:06PM 26 2004 WILLIAM JULY /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA HOSFITA HINGE 1 If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 10KM 20 F 58 214.44.8265 Yrs. Director 07-06-1946 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show 1 X Yes 2 No MD NIA BALTIMORE Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 1226 E. MADISON STREET 21202 USA 238 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status er than "natural", or item Ine Medical Examinar nit. Pages 1 and 2 should be filed within 72 hours after cariment of Health and Mental Hydjene.
ordant: If tem 27 is marked other than "natural; or itee injury or other traumatic event, its Medical Exeminating. I □ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CASHIER SERVICE STATION 12 TH GRADE NA 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) LINK Be MILDRED BLUE ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANNA DICKENS 6432 CRAIGMONT RD. BALTO. MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07.31.04 RANDAUSTOWN, MD KING PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 190 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE any ir 5151 BALTO. NATI PIKE, BALTO. NO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** 6 PAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): -burialas the burial Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by END STAGE KIDNEY DISEASE 3 Probably 4 MUnknown 1 □ Yes 2 □ No been END STAGE CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☒ No 24a. Was an has autopsy performe PULMONARY HYPERTENSION END STAGE certificate 1 ☐ Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospitaf: 1 ⊠ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No after death.

Director: A in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours aft To the Funerel Di completely filled in t 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number licola Totoles M.D. 26 RES000 JULY . 2004 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND, 21287 NICOLA ZETOLA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 9 2004 Spark Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2020 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Physician 2004 27, 4:53 A M Laverne H. Boyer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville 715 Maiden Choice Lane Parkview 111 If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F 81 217-12-3464 March 24, 1923 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State item 27 le marked other then "naturel", or items 23a or 28e-f ebov other treumatic event, the Medical Evandour must be notified at 1 Tyes 2 No Maryland Baltimore Catonsville Be Completed by Funeral Director 10f. Zip Code 21228 10g. Citizen of What Country? 10e. Street and Number United States 715 Maiden Choice Lane Parkview 111 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Emma Ay 0 Henry Hirschman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 715 Maiden Choice Lane Parkview 111, Catonsville, MD Charles N. Boyer - husband item 27 20c. Location - City or Town. State Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition Pages 1 July 30, ₽ 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) = 5 Department of Importent: If eny injury or once. Loudon Park Cemetery 2004 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Congestre /Medical Due to (or as a consequence of) Examiner Har Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No certificate 2 No Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Viesidence 6 | Other (Specify) 1 ☐ Yes 2 ☐ No ၉ ierel Director: After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide within 24 hours a To the Funerel I 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M an 0 22/1 DAMZAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL **2 9** 2004

OLD FREDERICK ROAD, #18, BALTEMORE, MARYLAND

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 19 **Physician** July 2004 3:00p.[™] Douglas Burns /Medical 4b City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 2710 Beethoven Ave 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2 F Yrs. 08 VΆ **Director** 231-24-9607 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location in than "natural", or Items 23a or 28a-f show the Medical Examinating the colling at XXYes 2□No <u>Baltimore</u> MD NA Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 U.S.A. Funeral 2710 Beethoven Ave 12. Was Decedent Ever in U.S. Armed Forces? TX☐Yes 2☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Enterprise Paper Manager 12th grade na other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental Alberta Chambers Hubert Burns 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 09 of Health 2710 Beethoven Ave, Baltimore, Md 21207 Bernice Burns-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department o Important: If any injury or Garrison Forest Vet. 7/26/04 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West any ir 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 28a. Part 1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final it ease or condition resulting in death) Metastal Coton **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9☐ Unknown 9 Unknown signed by d be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy performed? (es 21 No has 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 X lesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural 5 Pending Attending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Maryland 21215-0036

Baltimore,

o.

Records,

of Vital

Division

DHMH 17 Rev 1/2001

Cemolitanas

31. Date filed (Month, Day, Year)

3 / hame and address of person who completed cause of death (Item 23a, (Type, Print)

32. Régistrar's Signature

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10N Checke Sheet Bathmane rar's Signature

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DHMH 17 Rev 1/2001

ORIGINAL

		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 0.0 1										
			Registrar									
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	h #5	Ē	10e. Street and Number			10f. Zip Co	ode		10g. Citizen of What C	country?		
	738 C	<u>e</u>	2901 Tennessee A	venue			21227		United S	tates		
	deat deat	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Deceden	nt of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Am Black, Wh			
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5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Evandraer must be rodified at	Completed	15. Decedent's E (Specify only highest g	ducation	16a.	Decedent's Usual (Occupetion done during most of wo	orking	16b. Kind of Business	s/Industry		
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ā	ould be 1 Menta narked natic ev	To E	Charles A. Bergm	an			Maude	Gallent				
Maryland	To Comment		19a. Informant's Name/Relationship		19b.	Mailing Address (S	Street and Number or R	ural Route Numbe	r, City or Town, State,	Zip Code)		
Š	th a		Chales Edward Be	rgman Son	3	7 Browns	Cove Lane,	Glen Bu	rnie, MD 2	1060		
Ø,	1 ar Hea Hem		20a. Method of Disposition	20	20b. Place of	Disposition (Name	of	Date	20c. Location - City o			
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau		21 Signature of Pursuan	CANTONIA.	1012/		nmonds Ferr					
	40740	-	CAMMINA	JUNION	MICH	1				Approximate		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	y one cause on each lin	the death. Do r	ot enter the mode t		2723	1951,	Interval Between Onset and Death		
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1	/Medical		resulting in death)	Due to (or as a	a cons-cuence	of):	75 5M			a duic		
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ó			resulting in death) Last	Due to (or as a	a consequence	of):						
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Re	o - o	Ĕ						autop	med? death?			
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E .	Jing P	E E	Natural 5 Pending 2 Accident investigati	28a. Date of Injui (Month, Day	(Year)	njury M	: Injury at Work? 1 ☐ Yes 2 ☐ No		. ,			
Sic	Attending r death. ector: After by the fune	ical	3 ☐ Suicide 6 ☐ Could not	be 29a Blace of Inju	inc. At home, fa	rm, street, factory, o	_	28f Location /S	Street and Number or F	Bural Boute Number.		
Division of Vital Records,	or A offer Direction by	Certification;	4 Homicide determine	building, etc	(Specify)	iii, street, lactory, c	omce	City or Tow				
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	2	29a. Certifier 1 Certifying I	Physician: To the best of	of must be accessed	doath accurred	the time date and also	and dup to the	called(e) and manner	as stated		
	Hos Hos Fune Fune	edical		eminer: On the basis of	examination an							
	the 2 the mplet	Med	29b. Signature and title of certifier	and manner sta	ueu.	20c 1	License number		29d. Date signed (Mor	nth, Day, Year)		
	o T with		MIN X	> D64-3			16775	-	July 2	10001		
			The same of the sa	- 1-13					July 2	6 2009		
	10		30. Name and address of person wh		. 1		MIRISH	SHAM	2010			
	10			Hanouer		er 15	Baltimon	e M1.	0 6/22	5		
	Sta Regist		31. Date filed (Month, Day, Year)	2004 \ 2004	ar's Signature	6	A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item # 23a(d) per Physical Process of the Amend Item # 23a(d) per Physical Process of the Amend Item # 23a(d) per Physical Phys

			Allierid Item 1 - For State Registrar	State o	n Maryla		Inment tificate			ınd M		giene Reg. No.?	101.	22022
		1	1. Decedent's Name (First, Middle, La	ast)							2. Date of Dea	ıth		3. Time of Death
Я	Physic		Florence Leona B	runi							Month	Day 2.7	Year	10:40 рм
7	/Medi Exami		4a. Fecility Name (If not institution, gi		mber)		4b. City, To	own, or l	ocation o	f Death	July		2004	±
			Heritage Nursing	Center			Du	ında.	lk			В	altimo	ore
	Funeral		· · · · · · · · · · · · · · · · · · ·	Sex 1 □ M 2 🔯 F	7. Age (In yrs	s. last birthday)	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	Yeer)	9. Birth	nplace (Stete or Foreign
	Director		213 36 1766 Usuel Residence of Decedent	I WI ZIZI	64	Yrs.					Oct. 1, 1	939		yland
	land		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Mary First	to	Maryland Baltimo	ore	M	iddle R	iver							1 ☐ Yes 21 No
	r 28s	Director	10e. Street and Number				10f. Zip C	ode				10g. Citizen	of What Cou	untry?
	23a c	a	2155 Vailthorn Ro	l.			2	1220)			USA		
	ems erms	Funeral	11. Marital Status	12. Was Dec	edent Ever in l	U.S. 13.	Was Deceder	nt of His	panic Orig	jin? (Spe	ecify Yes or No- Rican, etc.)	14. F	Rece - Amer Black, White	ican Indian,
36	or h	by Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, Gir	2 XNo ve	ĺ	I□Yes 20		Specify:				city: Whi	
Ş	72 hours after death with the Maryland natural', or items 23a or 28a-1 show disal Examinat termotified at	d be	3 Widowed 4 Divorced	Year or D	Dates:	160 Dage	lanta Havali	2						
5	n "na	Completed	(Specify only highest gr	ade completed)		(Give	lent's Usual (kind of work DO NOT use	done du retired)	iring most	of worki	ng	16b. Kind of	Business/i	ndustry
21215-0036	d within piene. r than "	luo:	Elementary/Secondary (0-12)	College (1-4or 5+)		sewife					Own Ho	ome	
2	be filed vital Hygie of other lessent, I	Bec	17. Father's Name (First, Middle, Las	1)					18. Mother	r's Name	(First, Middle,	Maiden Surr	ате)	
Maryland	Menta Menta srked	10	Edward Nevin Flyr	ın				F	Berth	a El	izabeth	Graf	f	
a	2 shoul and Me is mark		19a. Informant's Name/Relationship								I Route Number	-		
	fealth im 27 her tr		Joseph Bruni (Hus	iband)	205	September 1997			ı Rd.	-	timore,			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene important: If item 27 is marked other than "natural", or items 23s or 28s-f show mit jujury or other treumatic svent, the Medical Examinat must be notified at ance.		20a. Method of Disposition 1 Burial 2 Cremation 3 [State	Place of Dispo	natory or other	er place)			ate	20c. Locatio	•	•
	permit. Pages Department of Important: If i any injury or once.		'4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Ho						31/2004	Balt	imore	Maryland
g	Depa impo any in		I Land R	1300	Ko	B:	Name and Puzdzi	nski	Fun	eral	. Home P	.A.		
			23a. Part1. Enter the disease, or con	polications that of	aused the dea	th. Do not ente	407_01 or the mode o	d Ea	such as c	n Av	renue Es	sex, 1	Maryla	and 21221 Approximate
	- Pnysician		Immediate Cause (Final	one cause on e	each line.	_				^				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	(or as a conse	quence of):	3410	14	14	/)	CIDE	NI		
	Examiner		Commentative line and distance	DI	BF T	45	MA	-11	117	115				
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse	quence of):	-							
	and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	SE12	Or as a conse	DI-	501,	D						
8/60,	cate be executed physician and the burial-transit	a E												
200	ficate phys s the	edical		d. Fanc	reacic	Cancer								
ROX	that the death certifi ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregn	nancy						23d [Date of deliv	IAN.
	death e atte d for	icia	in the past 12 months?	4□Pregn	oirth 2 ☐ Fet nant at time of		Ectopic preg Other (spec						Month	Day Year
j.	tt the by the tache	hys	9 Unknown	9□ Unkno	own									
λ, T	The law requires that te has been signed b vage 2 should be deta	ьу Р	Part II. Other significant conditions	contributing to de	eath but not re	sulting in the un	derlying cau	se given	in Part I.		23e. Did tol	oacco use co	intribute to t	the cause of death?
פ	v requir been si should	ted									1 🗆 Ye	s 2□No	3 Pro	bably 4 Thinknown
Vital Records,	has b	Completed									24a. Was a autops		. Were auto	opsy findings available empletion of cause of
	cate l	Co									perform 1 ☐ Yes 2		death? 1 🔲 Yes	202 No
<u> </u>	Physician: Th this certificate ral director, paq	Be	25. Was case referred to medical examiner?	Hospital:				1	26. Place	of Death	Check only on	θ)		
	Phys	2	1 ☐ Yes 2 № No 27. Manner of Death	28a. Date		ER/Outpatient 28b. Time of		Other:		-	ne 5 Reside			(y)
DIVISION OF	ding Ih. After funer	tion	1 ⊠Naturai 5 ☐ Pending 2 ☐ Accident investigatio	(Mont	th, Day Year)	Injury	M	Injury a Work? 1 ☐ Ye	u s 2 ⊟N		8d. Describe ho	w injury occ	urrea	
<u> </u>	i or Attanding after death. Director: Afte in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place	of Injury - At h	jome, farm, stre				-	8f. Location (St.	reet and Nur	nber or Run	al Route Number,
5	s afte	Sert	4 Homicide determined	buildi	ng, etc. <i>(Speci</i>	ity)					City or Town	, State)		
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Cartifying Pl	nysician: To the	best of my kn	owledge, death	occurred at 1	he time,	date and	place, a	nd due to the ca	use(s) and r	nanner as s	stated.
	the H the F the F hplete	Medicai	/	and man	ner stated.	ation and/or inv								
	To to	4	29b. Signature and title of certifier	1.0		4	29c. L	icense n	number	0	2	9d. Date sign	ned (Month,	Dey, Year)
			Juny!	Y/()	46/6	645	1/	' < ,	///	XX.		1/2	8D	4
	6		30. Name and address of person who	completed cause	e of death (Ite	m 23а) (Туре, F	rint)	119	01	da	- Xi	. A.	101	A
	Sta	te	31. Date filed (Month, Day, Year)	32. A	egistrar's Sign	ature	WAS	C1	/_	114	-10	12/0	1	<i>Y</i>
	Registr		JUL 2 9 2004	Per I	1.									

ORIGINAL

	1 - For State Registrar	State of Marylar		artment of tificate o			F	Reg. No. 0)4	23934
Physician	1. Decedent's Name (First, Middle, Last)					2	Date of Dea Month	ith Day	Year	3. Time of Death
/Medical		ward	Branc	lenburg			July 2			12:24 P M
Examiner	4a. Facility Name (If not institution, give s			4b. City, Town		of Death		4c. County		
	St. Joseph Hospit 5. Social Security Number 6. Sex		last birthday)	ff Under 1 Ye	ar ff Under		3. Date of Birth	h	inore 9. Birthp	lace (State or Foreign
Funeral Director		IM 2□F 68	Yrs.	Months Day	rs Hours	Min.	eb. 7	1936	Mary	y land
7	Usual Residence of Decedent	100 0	ty, Town or Lo	nation					1	0d. Inside City Limits
aryiar show	10a. State 10b. County		Parkt						1	1 ☐ Yes 2 ☐ No
the M	Maryland Baltimor	е	Parku	10f. Zip Code	9			10g. Citizen of	What Cour	itry?
iryland 21215-0036 should be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23s or 28s-f show matic event, if a Madical Examinar must be redified at To Be Completed by Funeral Director	1511 Rayville Ro	ad			21120			USA		
death	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of f Yes, specify C	of Hispanic Ori	igin? (Spec	ify Yes or No-	14. Rac Bla	ce - Americ	
after or its	1 Never Married 2 Married	1 X Yes 2 □ No ff Yes, Give		1 ☐ Yes 2 🛣 1			, , , , , ,	Specif	, , b	ite
21215-0036 led within 72 hours a sygiene. ner than "naturel", on the mudical Exam. It, the Mudical Exam.	3 X Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usuaf Oc	cupation			16b. Kind of 8	lusiness/Inc	tustry
in 72 in 72 in 72 in 72 in 72 in all	(Specify only highest grade	completed)	(Give	kind of work do DO NOT use ret	ne during mos ired)	st of working	g	100.11.100.1		,
d 2121 filed within Hygiene. ther than " ont, the Mail	Elementary/Secondary (0-12)	College (1-4or 5+)	Tech	nician				Cher	nical	Co.
ind be filed that the stand of the event,	17. Father's Name (First, Middle, Last)	Diagram						Maiden Sumar		
arylai should b ind Ment marked umatic	Lawrence		ndenbur		Reba		Mae	Whartor		
Maryland 21215-0036 nd 2 should be filed within 72 hours all tilh and Mental Hygiene. 27 is marked other than "natural", or riraumatic event, the Mudical Exam. To Be Completed by	19a. Informant's Name/Relationship (Ty	•		Address (Stre						Code)
e, N 1 and Health em 27	Karen L. Munn 20a. Method of Disposition	daughter 20b.	Place of Dispo	Charle esition (Name of		ve. La		20c. Location		wn, State
Pages nent of I	1 XBurial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)			vetera Vetera		7/29	/04	Crowns	ville	MD
🍅 다 된 원 원 🚽	21. Signature of Fyneral Service Licery		707.101	2. Name and Ad		-		Funera		
Ba permi Depa Impo any in	I Sik L. X		3	111 Mou	ntain F					5 1 · // ·
THE REAL PROPERTY.	23a. Part1. Enter the di lease, or compl shock, or heart fail re. List only or	ications that caused the dea ne cause on each line.	th. Do not en	er the mode of	tying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
Physician	fmmediate Cause (Finaf disease or condition	Metas		on smel					V	9 months
/Medical Examiner	resulting in death)	Due to (or as a consec	quence of):			1				
		Due to for as a conse	uence of:							
executed in and in-transit	cause. Enter Underlying Cause (Disease or injury that initiated events									
Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examin	resulting in death) Last	Due to (or as a conse	quence of):							
8760, sate be exphysician the burial		d							-	
Box 68 Beth certifica attending ph I for use as th	IF FEMALE:	NO. If we extreme of progr			1			00 1 7		
.O. Box 68 the death certification of the attending place as the death for use as the strength of the second for the second fo	in the past 12 months?	23c. If yes, outcome of pregnume of Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	aldeath 3	Ectopic pregna Other (specify				7	ate of delive onth	Day Year
P.O. hat the de by the de by the detached	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	36411 36	_ other (specin)	/					
Is, P.O. res that the de igned by the ab detached by Physic	Part II. Other significant conditions co	ntributing to death but not re	sulting in the t	nderlying cause	given in Part	ł.	23e. Did to	obacco use con	tribute to th	ne cause of death?
cords v requires been sig should be	Keetal	bleeding					1 🗆 Y	res 2□No	3 Prob	abiy 4 Unknown
Record The law requir te has been siage 2 should ompleted		/					24a. Was		prior to co	psy findings available mpletion of cause of
The law page 2 compl							perfo	rmed?	death? 1 ☐ Yes	2 🗆 No
of Vital Records, Physician: The law requires t this certificate has been signe tal director, page 2 should be e TO Be Completed by	25. Was case referred to medical examiner?	to enite le		1		e of Death	(Check only o	ne)		
Of \Officers	1 ☐ Yes 2 No 27. Manner of Death		ER/Outpatie	IL 3 DOA				dence 6 🗍 Oti		y)
Affair fune	1 Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury		njuryat Work? 1 □ Yes 2 □			,,		
Division To Attending after death. Director: After Jin by the fune	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, st	reet, factory, offi	ice	2	8f. Location (S	Street and Num	ber or Rura	I Route Number,
Division of the following Parties of Attending Parties after death. all Director: After the funeration by the funerations.	4 Homicide	building, etc. (Spec	iry)				City of You	vii, State)		
Division of Vita Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification; To Be 6	(Check only 2 Medical Exam	sician: To the best of my kn iner: On the basis of examin	nowledge, dear nation and/or in	h occurred at th	e time, date ar ny opinion, der	nd place, a ath occurre	nd due to the d at the time,	cause(s) and m	anner as s and due to	tated. the cause(s)
the H thin 24 o the F emplete	one) 29b. Signature and title of certifier	and manner stated.			ense number			29d. Date sign		
To To o	R. A.	Plan				87				
	30. Name and address of person who c	omplete cause of death (Ite	em 23a) (Type	Print)	10	-	1277	00		
5	Paul Chane, ma	5601 Lock	Rava	Blod	Stel	07,	Battin	nove, 1	10	21239
State Registrar	31. Date fifed (Month, Çay, Year)	32. Registrar's Sign	nature	7	-					

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amena Etherington

Sinai Hospital of

29c. License number

-000

29d. Date signed (Month, Day, Year)

CRUTCH, CARLTON nore. Maryland 21215-0036

icia		 State Registrar 			Certificate of Death	Re	g. No 2004	2393
IUIA	_	1. Decedent's Name (First, Middle	, Last)			2. Date of Death	Day Year	3. Time of Death
ica	al -	Carlton			Crutch Jr.	July	25 200C	1530 p
e		4a. Facility Name (If not institution,	Specially	L. Line	4b. City, Town, or Location of Dea		4c. County of Dea	ith
ľ		5. Social Security Number		ge (In yrs. last bi	irthday) If Under 1 Year If Under 24 Hi	s. 8. Date of Birth	9. Bir	thplace (State or Fore
l		219-62-5281	X [X M 2□ F	47	Yrs. Months Days Hours Mir	08 03	56	ountry) MD
		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Location			10d. Inside City Limi
	٥	MD N	Λ	Balt	imore			1X Yes 2□N
	Director	10e. Street and Number	A	Dare.	10f. Zip Code	10	g. Citizen of What C	ountry?
	a C	1107 West La	nvale Str	eet	21217		U.S.A	•
	runerai	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Am Black, Whi	
	o y	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced	ed 1 ☐ Yes 2X If Yes, Give Year or Dates:		1 ☐ Yes XXNo Specify:		Specify:	Black
	ear	15. Decedent	's Education		a. Decedent's Usual Occupation	1	6b. Kind of Business	
	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or	5+)	(Give kind of work done during most of w life. DO NOT use retired)			
	5	12th grade	na		Construction Wor		Construc	tion Co.
ĺ	Be	17. Father's Name (First, Middle, I				ame (First, Middle, M	laiden Sumame)	
	2	Carlton Crut 19a. Informant's Name/Relationsh		19	b. Mailing Address (Street and Number or I	Morris Rural Route Number.	City or Town, State.	Zip Code)
				l.	Middle View Ct.	Baltimo		21244
	1	20a. Method of Disposition	-	20b. Place	of Disposition (Name of ery, crematory or other place)		Oc. Location - City or	
		ty Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ∐Removal from State pecify)	θ	Zion Cemetery 7/	30/04 B	altimore	, Md
		21. Signatura Funeral Service L	icensee V	.011	22. Name and Address of Facility March F/H West			
		7 Johnala	JU. AM	gitt	4300 Wabash Av			
		shock, or heart lailure. List of	complications that cause only one cause on each	ine.	not enter the mode of dying, such as cardi	ac or respiratory arre	St,	Approximate Interval Between
		Infriediate Cause (Final						Onset and Death
		resulting in death)	a	ivalia e	civing the miles			Onset and Death
		resulting in death)	a	s a consequence		ue		Onset and Death
	ner	resulting in death)	Due to (or a.		on: the heart dise	ue		Onset and Death
	amlner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a)	s a consequence	on): the heart disection	ue		Onset and Death
ı	ă	resulting in death) Sequentially list conditions, fary, leading to introduct cause. Enter Underlying Cause (Disease or injury)	b. Due to (or a)	s a consequence	on): the heart disection	ue		Onset and Death
1	ă	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a)	s a consequence	on): the heart disection	11-6		Onset and Death
	Ä	Sequentially list conditions, fary, leading to influed accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a Du	s a consequence s a consequence s a consequence	of): the heart disection of):	ue	23d. Date of de	Onset and Death
ı	ă	resulting in death) Sequentially list conditions, lary, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or and to do an	s a consequence	of): the heart disection of):	11-6	23d. Date of de Month	Onset and Death
	Ä	Sequentially list conditions, flary, leading to infinite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or and b. Due to (or and c. Due to (or and d. Due to (or a	s a consequence s a consequence s a consequence e of pregnancy 2 Fetal deat at time of death	he hembed like hem		Month	Onset and Death
	by Physician/Medical Ex	Sequentially list conditions, flary, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or and b. Due to (or a	s a consequence s a consequence s a consequence e of pregnancy 2 Fetal deat at time of death but not resulting	he heart alsee hoth: h 3 Ectopic pregnancy 5 Other (specify) in the underlying cause given in Part I.	23e. Did tob	Month acco use contribute t	Onset and Death S m Jh v c Silvery Day Year o the cause of death?
֡	by Physician/Medical Ex	Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	Due to (or and b. Due to (or a	s a consequence s a consequence s a consequence e of pregnancy 2 Fetal deat at time of death but not resulting	he hembed like hem	23e. Did tob 1 ☐ Ye:	Month acco use contribute ts 2 □ No 3 □ P	Onset and Death Smith Day Year o the cause of death? robably 4 (2)Onkno
֡	by Physician/Medical Ex	Sequentially list conditions, flary, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or and b. Due to (or a	s a consequence s a consequence s a consequence e of pregnancy 2 Fetal deat at time of death but not resulting	he heart alsee hoth: h 3 Ectopic pregnancy 5 Other (specify) in the underlying cause given in Part I.	23e. Did tob. 1 □ Ye: 24a. Was an autopsy	Month acco use contribute ts 2 \(\text{No} \) 3 \(\text{P} \) 24b. Were a prior to	Onset and Death Smithum Smithum Day Year o the cause of death? robably 4 Donkno utopsy findings availa completion of cause
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	ertification; To Be Completed by Physician/Medical Ex	Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or and b. Due to (or a	s a consequence s a consequence s a consequence e of pregnancy 2 Fetal deat at time of death but not resulting but not resulting yet. Steen 2 EP/O jury ay Year) 28b. st of my knowledg of examination a	h 3 Ectopic pregnancy 5 Other (specify) in the underlying cause given in Part I. Capture for June 26. Place of D Putpatient 3 DOA Other: 4 Nursing Time of Injury M 1 Yes 2 No larm, street, lactory, office	23e. Did tob. 1 Yes 24a. Was an autopsy perform 1 Yes 2 eath (Check only one 28d. Describe how 28f. Location (Str. City or Town, ce, and due to the cacurred at the time, da	Month acco use contribute to s 2 \(\) No 3 \(\) P 24b. Were a prior to death? 1 \(\) Yes acco use contribute to s 24b. Were a prior to death? 1 \(\) Yes acco of the contribute to s acco use contribute to s 24b. Were a prior to death? 1 \(\) Yes acco of the contribute to s acco of the contrib	Onset and Death Smile v Day Year of the cause of death? robably 4 (Denknow utopsy findings availal completion of cause of secify) fural Route Number, s stated. e to the cause(s)

DHMH 17 Rev 1/2001

State

Registrar

JUL 2 9 2004

		For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of F			giene Reg. No. () () ()	00000
Physic		1. Decedent's Name (First, Middle, La HARRY	st)	CARROL			2. Date of Dea Month	ath CUU	ar 9:30 A M
/Med Exami		4a. Facility Name (If not institution, giv Saint Joseph		Center	4b. City, Town, o	Location of Dea	ath	4c. County of D	
Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		v, Year	Birthplace (State or Foreign Country)
e Maryland 3a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County N	A	10c. City, Town or Lo	Timore				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with th 3a or 28	I Director	10e. Street and Number	TORY A	ve	10f. Zip Code	2123		10g. Citizen of What	Country?
21215-0036 4 within 72 hours after death with the Maryland sjene. In than "naturel", or Itams 23e or 28e-f show the Marical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tes 2 N 1 Yes, Give Year or Dates:	0 13.5	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or No- irto Rican, etc.)		American Indian, White, etc.
21215-0036 d within 72 hours afl giene. ar than "natural", or the Medical Exam	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed) College (1-4or 5-	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking	16b. Kind of Busine	ess/industry
N 75 5 5	To Be Col	17. Father's Name (First, Middle, Last	RROLL		COAL		ame (First, Middle,	•	OR CORT.
Malth a 27 is		19a. Informant's Name/Relationship (Type, Print) ARROLL	100	111	and Number or F		r, City or Town, Stat	20, Zip Code) 21234
Baltimore, Dermit. Pages 1 ar Department of Hea Important: If item any injury or othe		20a. Method of Disposition Burial 2 Cremation 3 4 Donation 5 Other (Special			psition (Name of matory or other place) D . Cen _	7	Date 31 of	20c. Location - City	
Baltimo permit. Pag Department Important: It any injury o		21. Ignature Funeral Service Lice			Name and Address HARTIEU N	ss of Facility AULER FORD RD	STellA F	M 212	ne CHD
Physician /Medical		23a. Part . Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	θ.	er the mode of dyin	g, such as cardii	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	. PNEUMON	consequence of):					
58760, ficate be executed physician and s the burial-transit	dical Exan	that initiated events resulting in death) Last	c	consequence of):					
Geath certif	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at the 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ecords, P.O. law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of CANCER OF STOMA		t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to		e to the cause of death? Probably 4 Unknown
The The page	Completed	DIABETES MELLIT ALZHEIMER'S DIS		ТТА			24a. Was autop perfor	sy prior	
Of Vital P Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🐪 No	Hospital:		nt 3 DOA Cth	OF.	eath (Check only o	ne) ence 6 □Other (S	Spaciful .
ding h. After	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	/ 28b. Time o	f 28c. Injun Wor			ow injury occurred	рөспу)
Direction	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Inju building, etc.	ry - At home, farm, str (Specify)	reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
ne Hospital n 24 hours a na Funeral I	Medical	29a. Certifier (Check only one) Certifying Pl	nysician: To the best of miner: On the basis of and manner stat	examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time, o	cause(s) and manner date and place, and	r as stated. due to the cause(s)
To the I within 2 To tha I complet	M	29b. Signature and title of certifier	and -		29c. Licens	e number		29d. Date signed (M 7 - 26 - 01	
9		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,		house hand from P.		1	
St	tate	31. Date filed (Month, Day, Year)	32. Registra	to hand bood footo bear 8 to 19	, ,	WSON.	MARYLAN	D 21204	

DHMH 17 Rev 1/2001

Registrar

2 9 2004

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Division of Vital Records,

onni

	1	For State Registrar	State of Ma	-	epartment of F Certificate of			giene Reg. No. () () (;	23939
Physicia	n	Decedent's Name (First, Middle, Last JOHN		DIZE			2. Date of Dea Month	Day Yeer	3. Time of Death
/Medica Examine	er	4a. Facility Name (If not institution, give Peninsula Legion	al Redica	l Center	- Sali	r Location of Death		4c. County of Death	
Funeral Director		217-14-0341	x 7. Ag XIM 2□F	e (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day January 2	9. Birth (, Year) 9. Birth (Col 29, 1922 Mar	nplace (State or Foreign untry) yland
aryland show	.	Usual Residence of Decedent 10a. State 10b. County Maryland Somers	ant.	10c. City, Town o	r Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
death with the Maryland rms 23a or 28a-f show rms to notified at	Olrecto	10e. Street and Number		CE	10f. Zip Code			10g. Citizen of What Co	
death w	Funeral Director	3107 Calvary Road	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H	21817 Hispanic Origin? (Span Mexican Puerly	pecify Yes or No-	U.S.A. 14. Race - Ameri	
hours after tural; or ite	٦	1 Never Married 2 X Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ f If Yes, Give Year or Dates:	∾ World War II	1 ☐ Yes 2 ☒ No	Specify:	o riidan, did.j		hite
on 72 ni	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5	(C)	ecedent's Usual Occup live kind of work done fe. DO NOT use retire Sembly	during most of wor	king	16b. Kind of Business/I	•
yiang < 12 ould be filed with Mental Hygiene, arked other than atic event, then	Be	17. Father's Name (First, Middle, Last) Harland Dize	· · · · · · · · · · · · · · · · · · ·	AS	sembly			Paint Brus Maiden Sumame)	h Mig.
aryian aryian should be and Mental s marked o	으	19a. Informant's Name/Relationship (T)	ype, Print)	19b. M	tailing Address (Street		Le Mae Do ral Route Numbe	Orman r, City or Town, State, Z	lip Code)
C, Ma 1 and 2 s Health an am 27 ls r thar traur		Tiny Dize (Wife) 20a. Method of Disposition		20b. Place of D	07 Calvary		Crisfield Date	d, MD 2181 20c. Location - City or	
Saltimor Dermit. Pages Department of mportant: If it any injury or o		1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,			crematory or other pla e Memorial Pa		0/04	Crisfield,	
baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		21. Signatur Pup fal Service Ligen Robert H. Brads	hadela	A	22. Name and Addre Bradshaw & 306 W. Mai	ss of Facility Sons Fur	neral Hor	me , MD 21817	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused	the death. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
	ler	disease or condition resulting in death) Sequentially list conditions, in the conditions cause. Enter Underlying	bru	a consequence of) a consequence of)	Sial!	Infai	re	٦	
od rou, icate be executed physician and the burial-transit	dlcal Examin	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	al a consequence of)	Failure	<u> </u>			
death certified attending	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		23d. Date of deli Month	very Day Year
acords, F.O. law requires that the as been signed by th 2 should be detache	2	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	ne underlying cause gr	ven in Part I.		obacco use contribute to ′es 2 □ No 3 □ Pro	1 /
10 E E C	Completed						24a. Was a autop. perfor	an 24b. Were au prior to death? 2 No 1 Yes	topsy findings available completion of cause of
OT VICAL Physician: 1 r this certificat ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	U	Ott	or	th (Check only or		
Phy Phy of	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		ne of 28c. Inju	4 Nursing H		lence 6 Other (Special Control of the Control of th	ify)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, et	c. (Specify)	, street, factory, office		City or Tow		
n 24 hou n 24 hou he Funei oletely fill	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best iner: On the basis of and manner st	f examination and/	death occurred at the ti or investigation, in my	me, date and place opinion, death occu	, and due to the or rred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the within To the complex c	Σ	29b. Signature and title of certifier	1 4 1		29c. Licens			29d. Date signed (Month	4
6		30. Name and address of person who of the service of person who do not be a service of person who do not be a service of the s	omplete cause of c	leath (item 23a) (Ty	rpe. Print)		0.0	1090	702/
	e	31. Date filed (Month, Day, Year)	Megers 32. Registr	ar's Signature	ween SY	100 DV2C	u zax	1110 218	07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:00 AM 10MAS 26 2004 TULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2□ F Months Days Hours Min 213-66-915 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other then "neturel", or items 23s or 28s-f show other traumatic event, it is Modical Exemples must be multiled at 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1735 aldi by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be 1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 Is any injury or other traun Pages 1 and 2 s ment of Health an LLE D 3 1234 20c. Location - City or Town, State ER 1735 WESTON AVE JULIA ANDERS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Byrial 2 Cremation 3 Removal from State ANATOMY GIFTS REG. 7/26/04 A Donation 5 Dther (Specify) 21. Sign eral Serv 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part1. Enter the disease shock, or heart failure. e, o complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, this only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** well og na rove disease or condition resulting in death) /Medical Due to (or as a consequence of): x ears **Examiner** Vasco lapath Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner certificate be executed the burial-transit 1001 Diabetes Due to (or as a consequence of): attending physician IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) ed by the a P.O. 9☐ Unknown 9 🗌 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 **24**No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nov P Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 No 2 1 Tes 3□ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: . d in by the f 6 Could not be within 24 hours after dea To the Funerel Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Ecrtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the

29b. Signature

an title of certifier

Foble

State Registra

30. Ni me and address of person who completed cause of death (Item 23a) (Type, Print) and ~021cs

6001

31. Date filed (Month, Day, Year) JUL 29 32. Refistrar's Signature 2004

29c. License number

29d. Date signed (Month, Day, Year)

Chapic, ST Bultimore in 21204

20004

			For State Registrar	State of Maryla		artment of I		,	giene Reg. NG. () () (;	23941
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Dav Year	3. Time of Death
	/Media	cal	Warren David	Fry		th Ch. Tour			23,2004	7:51 A ^M
4	Examir	ner	4a. Facility Name (If not institution, give stre			4b. City, Town, o		Death	4c. County of Death	
	Funeral		Frederick Memorial 5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	Freder:	If Under 24	Hrs. 8. Date of Birth	Frederick 9. Birth	place (State or Foreign
ı	Director		220 - 26 - 6453 №	2□ F 80	Yrs.	Months Days	Hours	Min. July / July	, 1924 Mar	yland
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	Manyli f sho	0	Maryland Frederick		Jeffers					1 ☐ Yes 2X No
	h with the 13a or 28a-	Funeral Director	10e. Street and Number 3502-A Fry Road			10f. Zip Code 21755			10g. Citizen of What Co	untry?
Baltimore, Maryland 21215-0036	y within 72 hours after death with the Maryland liene. r then "natural", or tlems 23a or 28a-f show tre Medical Exercit verrasst be rediffed at	þ	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Nas Decedent of H f Yes, specify Cub 1 ☐ Yes 2 XNo	Hispanic Origin an, Mexican, P Specify:	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White Specify: Wh:	, etc.
2-0	72 hc	Completed	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	16a. Deced	ient's Usual Occup kind of work done	pation during most of	f working	16b. Kind of Business/I	ndustry
121	within lene. then "	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	d)		17	
2	Hyg the nt,		17. Father's Name (First, Middle, Last)			Dairy Fa		Name (First, Middle,	Farming Maiden Sumame)	
an	Q 50 50 9	To Be	William E. H	rv				lary O. War		
ary	iges 1 and 2 should to f Health and Men If Item 27 is marke or other traumatic	-	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	g Address (Street	<u> </u>		r, City or Town, State, Z	ip Code)
Σ	is 1 and 2 of Health a ltem 27 is other trai		Mrs. Evelyn M. Fry,	wife	3502	-A Fry Ro	oad, Je	fferson, M	Maryland 21	755
ore	Pages 1 and the perference of the mint: If Item into or other iny or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem		Place of Dispo cemetery, crem	natory or other pla	ce)		20c. Location - City or 1	
Ë	Pag tment tant:		`4 ☐ Donation 5 ☐ Other (Specify)	R		Cemeter			Jefferson	n, Maryland
Bal	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Licensee	M00:	255	Keeney^di 106 East	na" Basf Church	ord PA Fur Street, F	neral Home Trederick, N	1D 21701
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	TIC A		-	Dissect		Approximate Interval Between Onset and Death I HOME
8760,	rate be executed shysician and the burial-transit	edical Examiner	Saque fiely set ou offices, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗆	Ectopic pregnanc	y		23d. Date of deliv	rery Day Year
rds, P.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contrib	outing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.		bacco use contribute to	. /
of Vital Records,	The law ate has b page 2 st	Completed						24a. Was a autops perform	sy prior to co	opsy findings available ompletion of cause of 20 No
ΖĬ		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	oital: 1 ☐ Inpatient 2	X ER/Outpatien	t 3 DOA Ott	an	Death (Check only or		
of		—	27. Manper of Death	28a. Date of Injury	28b. Time of	28c. Injur	4 Nursii		ence 6 Other (Spec	fty)
ion	Attending F r death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)		rk? Yes 2 □ No				
Division	al or Attendates after death	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (Si City or Town	treet and Number or Rui n, State)	al Route Number,
	To the Hospitel or Attent within 24 hours after deall To the Funeral Director: completely filled in by the	ledical C	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of my ki On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the tire tirestigation, in my o	me, date and pl ppinion, death o	lace, and due to the concourred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 2. To the I complete	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed (Month)	
•			* X Kiluw	MD		D	22037		7/23/	2004
	12		30. Name and address of person who comp	610		· ·		3 runswic	7/23/2	1716
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 9 2004	32, Registrar's Sign	nature	Sparks	<			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Year **Physician** Month PM 1202 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTICORF CITY
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. CONTER 9 DOMISS HOPKINS BANGEL MEDICAL 8. Date of Birth (Month, Day, Year) 5. Social Security Number → 6. Sex 12 M 2□F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country), **Funeral** Yrs. Director 66 NOVEMBER 15, 1937 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at MD 1 Yes 2 No Director BA HAMURE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 36 38 2/2/3 4.5.0 238 AVE Pages 1 and 2 should be filed within 72 hours after death venent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BIAC 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 54881 Bethlehen StEEL Bethelehem 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Tenu Mary 19a. Info ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If Item 27 is any injury or other trains once. Bottoming MD 3638 Chestertield MAN Ford 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Albutus Mensieral CEM * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BEAS FUNERAL HOME Extración Buth St BASTAMONS MD 2/2/3 1129 N CARline 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) TEMORRHAGE 4 deys a NTRACRANIAL /Medical Due to (or as a consequence of): Examiner 10 40005 1 HYPERTENSION Sequentially list conditions, any backing Is immunated cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death Month Year 5 Other (specify) 1 Yes 2 No P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown CORDNARRY page 2 should 24b. Were autopsy findings available prior to completion of cause of death? ARTERY PERIPHERAL certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 9 1 ☐ Yes 2 No 1° Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) July 21, 2004 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PUTICES. 4940 EASTERN AVENUE HANS BALTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUL 2 9 2004

			1 - For State Registrar		ryland / Dep <i>Ce</i>	artment of F			ene	11.	239	1. 2
	Physic /Medi		Decedent's Name (First, Midd HARRY	le, Last)	GREEN	IBERG		2. Date of Death		2004	3. Time o 3:15	P м
	Examii		4a. Facility Name (If not institution 2502 SUMMERSO 5. Social Security Number	N ROAD		4b. City, Town, o	BALTIMOF		4c. County	В	ALTIM	
	Funeral Director		212-01-6142 Usual Residence of Decedent	1 M 2 F 7. Age	(In yrs. last birthday) 91 Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day JUNE 18	,1913	9. Birthpli Count	ace (State of	or Foreign
	show	2	10a. State 10b. County		10c. City, Town or L					10	d. Inside C	
	the Marylan 28e-f show notified at	Director	MD BA	LTIMORE	BALI	IMORE 10f. Zip Code		10	g. Citizen of V	What Count		2 X No
	23e or	al D	2502 SUMMERSO	N ROAD			21209		· • · · · · · · · · · · · · · · · · · ·		ISA	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumatic event, the Madical Examiner resumble notified at	by Funeral	11. Marital Status 1 Never Married 2 X Mar 3 Widowed 4 Divorced	If Yes Give	· WWTT	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛱 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, e		
1215-0	withla 72 ha ne. then "natur ie Modical.	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4or 5-	(Give	dent's Usual Occup. kind of work done of DO NOT use retired BILITY AN	during most of work ()	ing	6b. Kind of Bu			DMIN
d 2	filed with I Hygiene. other ther ent, The N	Be Co	17. Father's Name (First, Middle,		DISA	DILIII AN	18. Mother's Name				III A	DITIN.
Maryland 2121	2 should be filed withly and Mental Hygiene. Is marked other then eumatic event, Inc.M.	To B	BENJAMIN			NBERG	IDA				EBOWI	TZ
	and 2 sh lealth and m 27 is n her treun		19a. Informant's Name/Relations FLORENCE K. GR			ng Address (Street a					Code)	
Baltimore,	0 0		20a. Method of Disposition 1 X Burial 2 Cremation		20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place	CIRCLE	Date 2	0c. Location -	City or Tov		
Itim	Pa nen ant:	1	' 4 ☐ Donation 5 ☐ Other (S	Specify)		ER BENEFI			ROSED			
Ba	permit. Departr Importe any inju		Millow	Druga		2. Name and Addres				_	NC. 2120)8
8	Physician /Medical	0	23a. Part1. Enter the disease, o shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)	a. CEREP	the death. Do not enter a.	ter the mode of dyin	g, such as cardiac o	or respiratory arres	st,		Approximat Interval Bet Onset and I	e ween Death
	Examiner			Due to (or as a	consequence of);							ţ
	ted	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		consequence of):							
8760,	ate be executed hysician and the burial-transit		that initiated events resulting in death) Last	c. Due to (or as a	consequence of):							
9	entificate ling physi e as the l	Medic	IF FEMALE:	0.								
.O. Box	The law requires that the death certific tle has been signed by the attending p tage 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of deliver oth C	,	Yea r
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditi	ons contributing to death but	t not resulting in the u	nderlying cause give	en in Part I.		2 No			
of Vital Records,		Completed						24a. Was an autopsy performe 1 \(\text{Yes} \) 2 [ed?_ p	rior to comp eath?	sy findings a pletion of ca	available ause of
Vit	Physicien: this certific ral director,	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	t 2 ☐ ER/Outpatier	nt 3 DOA Othe	26. Place of Death er: 4 Nursing Hor			or (Cassiful		
	ding h. After fune	ertification; T	27. Manner of Death 1 Autural 5 Pendir 2 Accident investi	28a. Date of Injury (Month, Day	28b. Time of	28c. Injury Work	rat (? Yes 2 No	28d. Describe how				
Division	i Dife	Certific	3 Suicide 6 Could 4 Homicide determ	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	er or Rural I	Route Numi	ber,
	To the Hospitel within 24 hours a To the Funeral completely filled	edical (29a. Certifier 1 Crtifyir 2 Medical one)	ng Physician: To the best of Examiner: On the basis of e and manner state	examination and/or in	occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	ise(s) and mar e and place, a	nner as stat nd due to t	ted. he cause(s))
	To t To tl	ž	29b. Signature and title of certifie	ATTE	ENDING	29c. License		290	d. Date signed		ay, Year)	
	24	0	30. Name and address of person		YSica AN ath (Item 23a) (Type.	Print)	3371	-	7/27/0	24		
	3~		Dr. Harry Ka	plan, MD 40	000 OLD CLE	,	BACTIMU	E MD	21208	3		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	sala						

DHMH 17 Rev 1/2001

JD			1- For State of Maryland / Dep		of Health a of Death		giene	2301.1.
	Physici /Medio		1. Decedent's Name (First, Middle, Last) IROY LAMONT GOINGS			2. Date of Dea	100	3. Time of Death 0200A • M
}	Examir		4a. Fecility Name (If not institution, give street and number) 2820 Round Rd.	Balt	own, or Location of		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 124 1 1 1 242 1 7. Age (In yrs. last birthda) 1 1 2 1 7 Yrs.		Year If Under 2 Days Hours	Min. 8. Date of Birth (Month, Day	9. Birth Con	nplace (State or Foreign intry)
	e Maryland 8a-1 show	ctor	10a. State 10b. County 10c. City, Town or BALTIMO					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	s 23a or 2	Funeral Director	2727 GILES ROAD	10f. Zip Co	1225		10g. Citizen of What Cou	
9600	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene . Item 27 is marked other then "natural", or items 23a or 28a-1 show tiem 27 is marked other then "natural", or items Exarting the footified at	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2	No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White Specify: BLF	, etc.
21215-0036	filed within 72 Hygiene. other then "nat ant, the Medici	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) TH GRADE College (1-4or 5+) NA LA	edent's Usual Co e kind of work of DO NOT use r	done during most (retired)		CONSTRUCT	
Maryland	should be fill and Mental H is marked oth	To Be	17. Father's Name (First, Middle, Last) LESTER CROWDER		ELLA	s Name (First, Middle, MCFADDE	N	
	s 1 and 2 st of Health and item 27 is n other traun		ELLA ROSE 272'	GILES	RD.	BAUTO. M	r, City or Town, State, Zi 0 21225 20c. Location - City or T	
Baltimore,	t. Page rtment o rtant: If rjury or		'4 □ Donation 5 □ Other (Specify) HT × XIO		0	7.31.04	BALTO. MO	
Ä	permi Depa Impo eny ii		23a. Part1. Enler the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	AUGHN (151 BALT Iter the mode o	C. GREENI O. NATL' P of dying, such as co	E FUNERAL S LIKE, BALTO. ardiac or respiratory arr	SERVICE MD 21229 est,	Approximate Interval Between
1	Pnysician /Medical			- gri	wint	wounds		Onset and Death
	Examiner 5	iner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury					
8760,	ate be executed thysician and the burial-transit	cal Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.					
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregn			23d. Date of deliv Month	ery Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Dther significant conditions contributing to death but not resulting in the	underlying caus	se given in Part I.	23e. Did tol	pacco use contribute to t	he cause of death?
Vital Records,		Completed				24a. Was a autops perform	y prior to co	opsy findings available impletion of cause of
of	ding Physic h. After this ce funeral direc	ertification: To Be	25. Was case referred to medical examiner? 1 \(\begin{align*} \begin{align*} \text{Was case referred to medical examiner?} \\ 1 \begin{align*} \begin{align*} \begin{align*} \text{Hospital:} & 1 \begin{align*} \left	of	Other	28d. Describe ho	e) ance 6 SOther (Special ow injury occurred f Share	w (scene)
Division	i i i i	0	71.40	- Porch	1	220 Rous	nel road , B.	Himere, Mi)
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	Medical	29a. Certifier (Check only one) 1 □ Certifying Physician: To the best of my knowledge, dea (2 XMedical Examiner: On the basis of examination and/or is and manner stated.	nvestigation, in r	my opinion, death	occurred at the time, da	ause(s) and manner as sate and place, and due to	o the cause(s)
	^		2011 included AS: 30. Name and address of person who completed gause of death (Item 23a) (Type	0.	.C.M.E.		July 25, 2	
	Sta	te	7 BIUCLAT ALL 31. Date filed (Month, Day, Year) 32. Registrar's Signature	111	l Penn St	reet, Balt	imore, Mary	land 21201
	Registr	-	JUL 2 9 2004 Serve &	Sour	1			

DHMH 17 Rev 1/2001

			For State Registrar	State of Mary		artment of rtificate of		Mental Hy	/giene Reg. NB. 1	L 23915
\$191	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last) GRACE VIRGINIA 4a. Facility Name (If not institution, give	GRADE			or Location of Dea	2. Date of De Month 07. 24	2 - 2004 4c. County of	1
	Funeral Director		FUTURE CARE 5. Social Security Number 220.30.1418 Usual Residence of Decedent	7. Age (in	yrs. last birthday) Yrs.	BALTIU(If Under 1 Yea Months Days	r If Under 24 Hrs			9. Birthplace (State or Foreign Country) MD
	the Maryland	ector	10a. State 10b. County N A		City, Town or Lo				10g. Citizen of W	10d. Inside City Limits 1 MYes 2 □ No
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if tiems 23 a or 28a-f show important: if tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic evant, I'm Madical Examinat must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade)	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: cation e completed)	in U.S. 13.	Was Decedent of f Yes, specify Cu	upation		o- 14. Race Black	A - American Indian, , White, etc. BLACK
Maryland 212	should be filed with ind Mental Hygiene. s marked other than umatic evant, tre h	To Be Comp	Elementary/Secondary (0-12) 12 1H QRADE 17. Father's Name (First, Middle, Last) HERVIN CHAINBER	College (1-4or 5+) N / Λ		BOTOMIS	18. Mother's Na		HEAGH Maiden Sumame AMBERS)
altimore, Mar	Pages 1 and 2 she nent of Health and int: If Item 27 Is m iry or other traum		19a. Informant's Name/Relationship (Ty LINDA HEURY 20a. Method of Disposition 1 R Burial 2 Cremation 3 S 4 Donation 5 Other (Specify)	2 temoval from State	2021 Ob. Place of Disponsemetery, creit OUDON	ORLEAN sition (Name of natory or other pl PARK	07.	3ALTO . 1 Date 31: 04	MD. 2123 20c. Location - C BALTO . A	31 City or Town, State
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service License	1	vã 5	Name and Add UGHN C. 51 BAHO	ress of Facility GREAUE NATL' PIK	FUNERAL E. BALTI	SERVICE O. MO J	<u>22</u> 9
	/Medical Examiner // // // // // // // // // // // // //	Ilcal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Error Unidentying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):		Nisheren		ves me	Approximate Interval Between Onset and Death
P.O. Box 68	ne death certifics the attending phined for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date Mont	of delivery h Day Year
ords, P.	w requires that the been signed by should be detact	by	Part II. Other significant conditions con	rectitis	t resulting in the u	nderlying cause g	iven in Part I.		tobacco use contrib Yes 2 □ No 3	oute to the cause of death?
of Vital Records,	ician: The law r certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical	447			OS Pierre et De	1 ☐ Yes	psy property de de 2 No 1 [ere autopsy findings available or to completion of cause of ath? Yes 2 \(\text{No} \)
ion of Vii	utending Physician: death. ctor: After this certific y the funeral director.	ToB	examiner? 1 Yes 2 No 27. Manger of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury	28c. Inji	ther: 4 Nursing I		idence 6 Other	1 7 77
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	al Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - building, etc. (Si	pecify)			City or To	wn, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examination 29b. Signature and title of certifier	ner: On the basis of exal and manner stated.	mination and/or in	estigation, in my	opinion, death occu	urred at the time,	date and place, an	(Month Day Year)
	Sta Registr		30. Name and address of perso of o co Dalitet 3. 5a 31. Date filed (Month, Day, Year)	mpleted cause of death	Signature		76050 T Royal	Ave 8	Belt MD	21217

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland	-		of Health of Death			ene	23946
>	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last OY Y 4a. Facility Name (If not institution, give	Groenin	nge	R 4b. City, Tow	vn, or Location		Date of Death Month	Day No Year 2 8 200	3. Time of Death 2.10p M
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Y	ear If Under ays Hours	Min. 8.	Date of Birth (Month, Day,	Year) Co	NWWC hplace (State or Foreign buntry) ryland
	he Maryland 28a-f show cuified at	ector	10a. State 10b. County Maryland Baltimor	10c. City, T	Town or Lo	ım					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examiner Fust be natified at	Funeral Director	2300 Dulaney Val. 11. Marital Status	ley Road 12. Was Decedent Ever in U.S. Armed Forces?	13. \	10f. Zip Cod 21 D Was Decedent f Yes, specify (rigin? (Specify		g. Citizen of What Co USA 14. Race - Ame Black, Whit	erican Indian,
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Maryland	id 2 should be th and Mental 27 is marked o traumatic eve	To E	Aloysis Shet: 19a. Informant's Name/Relationship (Ty Mary Kay Nabit/Gra	pe, Print)			Ida reet and Numb rles St	er or Rural Ro		City or Town, State, 2	
Baltimore,	8 = 5		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State 20b. Place cemin	e of Dispo etery, cren Cathe	sition (Name on natory or other edral Co	ef place) BM.	Date 7/30/0	20	ore Md. 2 Oc.Location-City or altimore.	Town, State
Bal	permit. Pa Departmer Important eny injury	-	21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ness	Ru	ick Tows		eral H		1050 Yo c. Towson,	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due le r as a consequen	1)	abet	40 C V	Vle (li)	tus		Onset and Death
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>	<u>×</u> ∞ o	ToB	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient	3□ DOA	04		The second second	ce 6 ☐Other (Spec	city)
Division c	Jing After fune	Certification:	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	(Month, Day Year)	b. Time of Injury	М :	njury at Work? 1 🗌 Yes 2 🗍	No		injury occurred	
οį	i Diffe		4 ☐ Homicide determined 29a. Certifier t⊠ Certifying Phys	28e. Place of Injury - At home building, etc. (Specify)					City or Town, :	,	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examination) 29b. Signature and title of certifier	sician: To the best of my knowled ler: On the basis of examination and manner stated.	and/or inv	estigation, in m	e time, date an ny opinion, dea ense number	th occurred a	t the time, date	se(s) and manner as e and place, and due f. Date signed (Month	to the cause(s)
•	ر آ		30. Name and a dress of person who co	mpleted cause of death (Item 23	a) (Type F	Print)	52	74	0	July 2	8 m 500t
	J"		ERNESTINE WRIGHT				Y ROAD	TIMON	IUM, MI	D 21093	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature		and .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 9C04 /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** 1 №M 2 ☐ F Months Days Hours Yrs. Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r then "natural, or iteme 23a or 28a-f shov the Medical Evaniner must be notified at 1 Yes 2 No HARFORI Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1285. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene importent; if item 27 is marked other than any injury or other treumatic most College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be AMANDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 128 S. PHILADELPHIA BLVD. ABERDEEN, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Other (Specify) * 4 Donation ANATOMY GIFTS 21. Signatur neral S 22. Name and Address of Facility rvice L Daugherty Family Funeral Home And Cremation Center, PA 2601 Mountain Road - Pasadena, MD. 21122 , or complication like and ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Listenmy brue ed. In each line. Approximate Interval Between Onset and Death shock, or heart failur. immediate Cause (Final disease or condition resulting in death) Nece Cayco YCOUS **Physician** Head and /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the attending physicien end shed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 M Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy 1 Yes 2 NO After this certific funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 A ther (Specify) Medical Certification; To 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 2 🗆 No 1 🗌 Yes 2 Accident investigation thei Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier сотрыеть (Check only one)

Box 68760 o. of Vital Records. death. within 24 hours a Hospitel the

show

hours after

Maryland 21215-0036

Baltimore,

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clarkes (mg) (000) 31. Date filed (Month,

9

32. Resstrar's Signature

29c. License number

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29d. Date signed (Month, Day, Year)

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Box 68760,	
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	1		30. Name and address of person who	completed cause of c	eath (Item	23a) (Type, Print)	21 -	00	. 10	0-11	. 1	50 1/0	12.2	27
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Funeral Director		212-42-8614		9 Yrs. Months Day		Day, Year) C	ountry) MD
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the N	Director	MD NA 10e, Street and Number		BALTIMORE 10f. Zip Code		10g. Citizen of What C	ountry?
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ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of	Hispanic Origin? (Specify Yes or Nahan, Mexican, Puerto Rican, etc.)		
Depertment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic avant, the Medical Exeminar must be notified at 2008.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No			FRICAN
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Hygie other ant,	ပိ	12 th 17. Father's Name (First, Middle, Last))	CUSTODIAL	ENGINEER 18. Mother's Name (First, Midd)	FUNERAL HO	ME
Ked o	To Be	ROBERT H. HARR	IS		EULA M.	HARRIS	
E LI		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stree	et and Number or Rural Route Num	ber, City or Town, State,	Zip Code)
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Depertment of Health and Mental Hygiene. Important: If item 27 Ia marked other than any Injury or other traumatic avant, Ite Manace.		* 4 □ Donation 5 □ Other (Specif	y) VOS	HELL MEMORIAL			
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To t	Σ	29b. Signature and title of certifier North	Ma	~, M.D. 29c. Lice	D 27411	29d. Date signed (Mor	nth, Day, Year)
4		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	701 EASTERN	BLVD.	BALTIMOR 122)
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa			STI PO	
	rar	JUL 2 8 2004					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2305 Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** Roberta Marie Haase 27 2:25 July 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 251 Constant Avenue Severn 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min 1 ☐ M 2 🛛 F 66 219-34-9042 July 6, 1938 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28e-f show 1 ☐ Yes 2 1 No other traumatic event, the Medical Examiner must be nutifled Director Severn Maryland Anne Arundel 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5 United States Items 23a 21144 251 Constant Avenue Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married White ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3℃ Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event." Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) unk. 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Hope Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lynnda Ruth Bond - Daughter 251 Constant Avenue Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/30/04 Meadowridge Mem. Park Elkridge, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Gary L. Kaulman Funeral Home At MMP., Inc. 7250 Washington Blvd. elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive heard /Medical Due to (or as a consequence of) **Examiner** godopat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician anemic IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, page 2 should be 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown ertense 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No prior to co death? 1 \(\text{Yes} 1 ☐ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July-28T4 2004 D50870 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Shran Ando SVDS Signal Bell lane Clarksulle M) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 9 2004 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend Item #12 peratibit@adda8/3/04batesent of Health and Mental Hygiene

	Certificate of Death	Reg. N	0.0001
Physician	1. Decedent's Name (First, Middle, Last) Edward Hooper	July 26,	3: Time of Death 2004 1:31 PM
/Medical Examiner	4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Lo		c. County of Deeth
LXAMIIITEI	Civista Medical Center LaPlat	ta	Charles
Funeral Director		8. Date of Birth (Mooth, Day Year 5—1—26	9. Birthplace (State or Foreig Country) West Va.
ehow Nat	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limit
the Men 28a-f et notified	Md. NA Baltimore		1 ŽXYes 2 □ N
O offer death with the Meryle offer must be notified at funeral Director	10e. Street end Number 2301 E. Federal Street 21213		itizen of What Country? USA
d 21215-0020 filed within 72 hours effer death with the Meryland Hygiene. they than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at a Completed by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
I 21215-0020 lad within 72 hours eff ygiene "patural", or it, the Madical Exam Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade 15. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired) Steel Side		Kind of Business/Industry
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re, Maryla s 1 end 2 should I Health and Mani tem 27 is marke other traumatic	Ed Hooper Leola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	al Route Number, City	
e, Mg	Edward Hooper, Jr. Son 4911 Herring Run Drive	_	
Pages nt: If I	20a. Method of Disposition 1 Aburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park 7		ocation - City or Town, State
Baltim permit. Par Departmen Important: any injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Managle 32. If Parts	Baltimor	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	1101 E. No or respiratory arrest,	Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	DISIEN	Onset and Death
	SETEWAY DESCRIPTION)	x before
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68760, ificata be example of the purial as the burial edical Example of the control of the contr	Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):	4GNS	* Wess
	resulting in death) Last d. LARYNGRAL TUMOVR L	ad Attu	tolocecount
BOX death cert e attendin od for usa	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobecco	o use contribute to the cause of death
is, P.O. Box (es that the death certif es that the attending be detached for use as by Physician/Me		1 □ Yes 2	2 No 3 Probably 4 Anknow
requir		24a. Wes an auto performed?	opsy 24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec sician: The law certificate has b lirector, paga 2 s		1□ Yus 2	1 ☐ Yes 2 ☐ No
Vita	25. Was case referred to medical examiner? 1 Yes 2 Yes 2 Yes 2 Yes 2 Yes Ye	me 5 ☐ Residence	C DOthan (Consist)
n of ng Phys ter this maral d	27. Manner of Death 1 Defratural 5 Pending 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 1 Description	me 5 in Residence 28d. Describe how inju	
e spec	2 Accident	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
Hospital Hospital Euneral Staty filled	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, a end manner stated.		
To the within 2 To the comple	29b. Signature and title of certifier 29c. License number D = 2 0 6 2 9	29d. Da	ate signed (Month, Day, Year)
6	30. Name and eddres Person who completed cause of deeth (Item 23a) (Type, Print) George H Wathen MD 11345 Pembrooke Sq Ste 103	Waldorf	, MD 20603
State	31. Date filed (Month, Day, Year) 32. Registrer's Signature		

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** VERNA M. HOLBROOK 12:30P™ 22 2004 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hart Heritage Estates Street Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2√2 F Yrs. 97 216-22-3806 8/16/1906 Director North Carolina Usual Residence of Decedent 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location 23a or 28a-1 ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No MD Harford Street Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3900 Davis Corner Road 21154 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 'natural', or Items 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Importent: If Item 27 is marked other than any Injury or other traumatic event the Seamstress Manufacturing 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Frank Johnson Mary Josephine Trivett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Edwards/Daughter 3018 Grier Nursery Road, Forest Hill, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Bel Air Memorial Gardens 7/26/2004 Bel Air, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Henry Consestive Priysician YKARS disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine certificate be executed burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a s been signed by the should be detache 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 X No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies Assisted 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) CANE 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3988 July 23, 2004 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUIDIND SPAMUS 615 W. MALPHA. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1. Decedent's Name (First, Middle, L	ast)	-				-		2. Date of De	Reg. No.	Yea		Time of D	eath
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niner		4a. Facility Name (If not institution, gi		ər)				Location o	of Death		4c. C	ounty of De	eath		
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A C		Elmer Innerst						Gert	rude	Shiel	ds				
		19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a	nd Numbe	er or Rura	l Route Numb	er, City or T	rown, State	, Zip Cod	e)	
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once. To Re Completed by Funeral Director		21. Signature of Funeral Service Lic	ensee		Ga	ry L.	Kau	fman	Fune	ral_Ho	me At	MMP.	, Inc		
	-	23a. Part1. Enter the *sease, or co	molications that cau	sed the dea						r respiratory a		, Mar	App	roximate	
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2	IV IVIC	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7					23	d. Date of o	delivery		
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Maryland	Department of Health and Certificate of Death		ne OOOL OOF!
>	Physic /Med Exam	ical	1. Decedent's Name (First, Middle, Las John Edux 4a. Facility Name (If not institution, give	rd JONES	4b. City, Town, or Location of Dea	JULY :	Day Year 3. Time of Death
6 7	Funera Director	i	Forest Haven 5. Social Security Number 6. Se	Nursing Home	Catonsville	s. 8. Date of Birth	Baltimore 9. Birthplace (State or Foreign Country)
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show not, the Medical Examinar rount to rotified at	rector	10a. State 10b. County		own or Location ALTIMORE 101. Zip Code	100	10d. Inside City Limits 1 ⊠Yes 2 □ No
	r death with ems 23a o	Funeral Director	104 N. KOSSI	12. Was Decedent Ever in U.S. Armed Forces?	21221 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		Citizen of What Country? USA 14. Race - American Indian,
-0036	hours afte itural, or it	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi	1 ⊠Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Black, White, etc. Specify: BLACK
121215-0036	d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f shoy traumatic event, the Medical Examinar must be notified at	Completed	(Specify only highest grad Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last)	de completed) College (1-4or 5+)	ia. Decedent's Usual Occupation (Give kind of work done during most of wo lifte. DO NOT use retired) USTONIER SEVVICE	Rep 1	. Kind of Business/Industry 1.S. Postal Service
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	1 and 1 and		KATRINA JONES 20a. Method of Disposition	20b. Place	Bb. Mailing Address (Street and Number or R	TREET BY	Coation - City or Town, State
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 ⊠Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Lice)	Terrioval from State	RRUTUS DT	- 1	ALTIMORE, MD
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Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
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al Rec	ysician: The law i is certificate has be director, page 2 sh	Completed by				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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ō	Phys orthis oral dii	. To	1 Yes 1 No	1 □ Inpatient 2 □ ER/O	utpatient 3 DOA Nursing H	ome 5 Residence	
Division of Vital	Attending Ph er death. rector: After th by the funeral	Certification:	1 Atural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Injury Work? M 1 Yes 2 No	28d. Describe how inju	ury occurred and Number or Rural Route Number.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a Certifier 1 Certifying Phys	building, etc. (Specify)		City or Town, Stal	re)
	the H iin 24 the F iplete	Medical	one)	and manner stated.	 e, death occurred at the time, date and place nd/or investigation, in my opinion, death occur 	rred at the time, date ar	nd place, and due to the cause(s)
	To To COT	2	29b. Signature and title of certifier	1-00	29c. License number	29d. Da	ate signed (Month, Day, Year)
			Jasuen	Vallani	D28191		1/27/04
_	10		30 Name and address of person who co	inhered cause of death (Item 23a)	PARK HEIGHT	AVE BA	eto Min olone
F	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	6. 1	1 - 1 1	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 295 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 01-24-Year **Physician** 7:15 PM JONES JANNIE B /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE NA VALLEY STREET If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 KF NC 216.40.050 lal Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ? is marked other than "natural", or items 23e or 28e-f show traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Funeral Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21202 USA 1034 VALLEY STREET death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

Q TH GRADE College (1-4or 5+) CLERK LAW FIRM NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any liny or other traumatic event soice. KATIE DUNCAN BOSTON WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21202 ST. BALTO. MD. 1034 VALLEY JONES WALTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTO. MO 07-29-04 ARBUTUS * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
VAUGHA C. GREEVE FUNERAL
5.61 BALTO. NATL PIKE, BALTO. 21. Signature of Funeral Service License Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the isease, or complications that caused the death shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate interval Between Onset and Deat **Physician** disease or condition resulting in death) /Medical as a consequence of) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit that initiated events sician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached Ö 9 Unknown ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 3 Probably 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 1 Tyes 20 of Vital or Attending Physician: nedica 25. Was case referred to examiner? 26. Place of Death (Check only one, Be Cther: 4 ☐ Nursing Home 5 ☐ Residence ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Spec 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Division 1 Matural 5 Pending 2 🗆 No death. investigation 2 Accident the Diractor 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a 29a. Certifier I Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Daw Year) 29c. License number 29b. Signature and title of certified 32. Registrar's Signature State Registrar

RKD			For Unpend Item #23ac27 per me Co34 of Department of Health and M			gible.	2005	_
	Physicia	an.	Decedent's Name (First, Middle, Last)	2. Date of Death Month JULY		20 ⁶ 4	3. Time of D	
•	/Medic Examin	al	DSCAR T. JORDAN 4a. Facility Name (If not institution, give street and number) 1921 N. ROSEDALE STREET 4b. City, Town, or Location of Death BALTIMORE	JOLY		unty of Death		M
10	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 7. Age (In yrs. last birthday) Yrs. 6. Sex 1 Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day, DZ 13	Year)	9. Birth Cou	place (State or F intry)	Foreign)
	e Marylend le-f show	ctor	10a. State 10b. County 10c. City, Town or Location BALTIMORE				10d. Inside City 1 Maryes 2	
	th with the	Funeral Director	10e. Street and Number 1921 N. ROSEDALE STREET 21216	10	*	of What Cou		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene. If Heelih and Mental Hygiene. or other treumetic event, the Machical Examination must be notified at or other treumetic event, the Machical Examination must be notified.	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	E	Race · Ameri Black, White ecify: 13(
Maryland 21215-0036	vithin 72 houne.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A D A ELECTRONIC TECHA			of Business/Ir		
land 27	2 should be filed within and Mental Hygiene Is marked other then eurnatic event, Ine M.	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M Y JORD	laiden Sun			
		-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 4716 EDMONDSON A				(p Code) 21229	
Baltimore,	permit. Pages 1 and 2 Department of Heelth a Importent: if tem 27 is any Injury or other tre		cometent crematons or other place)	Date 2		on - City or T		
Balti	permit. Departinimporte any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility VALIGHT C. GREENER SIST BALTIMORE NAME	I'LPIKE 1	B4LTC	VICES ND	21229 Approximate Interval Betwe	
60,	P 2 2	licai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic Narcotism and Cocaine Use complications as a consequence of: Due to (or as a consequence of): b			yocard	Onset and De- ial Fib	rosi
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Division of Vital Records,	To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Certification; To Be (examiner?	h (Check only one ome 5 Resider 28d. Describe how continued to the continu	w injury oc	curred	riy)SCENE	Эr,
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edicai Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.					
	To the within 2 To the comple	Mec	29b. Signature and title of certifier 29c. License number			gned (Month		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200. C.M.E. 111 Penn Street, I			3,2004		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Resistrar's Signature	ALCHIOLE	.e r∗ici	гулан	-CICUI	

DHMH 17 Rev 1/2001

Registrar

			For	State of Maryland	-			Mental Hy	giene		
		_	State Registrar		Cei	tificate of l	Death		Reg. No.	01.	0 - 0 - 0
	Physicia		Decedent's Name (Eirst, Middle, Last)			Thorn		2. Date of De	Day	Year	3. Time of Dealth
	/Medic	al	Monkue			Nonno		July	23,0	2004	17.16
	Examin	er	4a. Facility Name (If not institution, give s	the state of the state of	Lar	4b. City, Town, or		oth C	4c. Col	inty of Death ∆	1
			5. Social Security Number 6. Sex	PKINS TOSP	st birthday)	If Under 1 Year	MOY C. If Under 24 Hr	S. 8. Date of Birt			nplace (State or Foreign
	Funeral Director			M 2□F 54	Yrs.	Months Days	Hours Mir		V. Year)	Col	Va.
			Usual Residence of Decedent								
	nylan show	_	10a. State 10b. County		Town or Lo						10d. Inside City Limits 1 X Yes 2 No
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	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show ha Medleal Exertinar transite rudillad at	Director	10e. Street and Number 1202 Pearleaf Ct			10f. Zip Code 21202			10g. Citizen US		untry?
	s 23	by Funeral		Was Decedent Ever in U.S	13.1		ispanic Origin?	Specify Yes or No	14.	Race - Amer	ican Indian
	iter d	F.	1 Never Married 2 Married	Armed Forces? 14 Yes 2 □ No	1	Was Decedent of H f Yes, specify Cuba		rto Rican, etc.)		Black, White	e, etc.
93	al', o		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 21□No	Specify:		Spe	cify: B1	lack
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "natural", or Items 23a or 28a-f show then traumatic event. The Medical Examinant manks redifficed at	Be	John	Perre	ear			siah		Johnso	on
2	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (Tv.	pe, Print)	19b. Mailir	ng Address (Street a	and Number or I	Rural Route Numbe	er, City or To	wn, State, Z	ip Code)
	od 2 s Ith ar 27 ls r trau	1	Marie Johnson	Wife		Pearleaf				21202	
ē,	s 1 and 2 f Health item 27 I		20a. Method of Disposition	CO	ace of Dispo	sition (Name of natory or other place	(a)	Date	20c. Location	on - City or 1	Town, State
Ê	Pages nent of int: If its iry or o		1 ☐ Unit 2 ☐ Cremation 3 ☐ R 1 ☐ Cremation 3 ☐ Other (Specify)			Forest \		30-04	Owing	s Mill	ls, Md.
Baltimore,	permit. Pages 1 at Department of Hea Important: If item any injury or othe		21. Signature of Funeral Servige License	" Cork		Name and Address		Balt:	imore, North	Md. Ave	21202
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death.	. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between
18	Enysician i		Immediate Cause (Final disease or condition	Muncar a	0:01	To	I va	1:00			Onset and Death
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	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ence of):						
	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to fee as a conseque	oneo of):					-	
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rds	quires in signi uld be	d ba						1 🗆 ۱	res 2□N	o 3□Pro	bably 4 Unknown
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Vital		BeC	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o			
of V	Q 5. X	70	1 ☐ Yes 2 No	lospital: 1 Inpatient 2	R/Outpatier		4 🗀 ianizini	Home 5 Resid	dence 6 🗆	Other (Spec	rify)
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Division	l or Attendater death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, sti	eet, factory, office		City or Tov		ımber or Hu	ral Route Number,
L	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier Certifying Physical Certification Certificati	sician: To the best of my know	vladro doc	h occurred at the time	ne date and cla	ce, and due to the	rause/s\ ass	I manner an	stated
	Hos 24 hc Fun etely	Medical	(Check only 2 Medical Exami	ner: On the basis of examinati and manner stated.	on and/or in	vestigation, in my o	pinion, death oc	curred at the time,	date and pla	ce, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier	71	/	29c. Licens	e number		29d. Date si	gned (Month	, Day, Year)
	11		1	7/////	1	M	37	299	1.11	/n_	16. 2mk
	V		30. Name and address of person who co	empleted cause of death (Item	23а) (Туре,	Print)	<u> </u>		7,	0	a su
	IVA		Stevents	chilman	600	N. Wolfe	Street	of BAH	MORE,	MAY	and 21287
	Sta		31. Date filed (Month, Day Year)	2. Registrar's Signatu	ure	Sporks				//	- #
	Regist	rar	JUL 6 0 2004	/		4					

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			Registrar 1. Decedent's Name (First, Middle, Las	et)		illicate of	Dealit	2. Date of De	Reg. No. U] 4	3. Time of Death
	Physici		Ma	rgaret E.	Johnson			July 2	Day 2004	Year	2:57PM M
	/Medio Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of D		4c. County		2.5/1(1
			Southern Maryland			Clinton			Princ	e Geo	rge's
	Funeral		5. Social Security Number 6. Se	Ou -O-	In yrs. last birthday) Yrs.	If Under 1 Year Months Days		Ain(Month, Da	ry, Year)	9. Birthp	lace (State or Foreign itry)
l,	Director		273-05-4628 Usual Residence of Decedent	^{□ M 2 X F} 92	113.			June 4	, 1912	Ohio	
	ytand now	١.	10a. State 10b. County		0c. City, Town or Lo					1	0d. Inside City Limits
	B Mar	ctor	Maryland Prince G	eorge's	Oxon Hill						1 ☐ Yes XX No
	or 28	Director	10e. Street and Number			10f. Zip Code	20745		10g. Citizen of V		try? SA
	s 23a		6909 Jarrett Ave.						144.0		
	ter de	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of I If Yes, specify Cub	Hispanic Origini pan, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	Blac	e - Americ ck, White,	an Indian, etc.
920	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify	" Whi	te
2-0	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or itams 23a or 28a-1 show event, I've Medical Exartinar russt be notified at	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual Occu kind of work done	pation	working	16b. Kind of B	usiness/Ind	dustry
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22	e filed within al Hygiene. other than vant, I'm Wu		17. Father's Name (First, Middle, Last)	2	2601	etary	19 Mother's	Name (First, Middle,	Utility		pany
and	d be f antal h ad of	Be C	William Johnson					Ashby	Walder Surian	16)	
Baltimore, Maryland 21215-0036	s 1 and 2 should be f Health and Mental item 27 is markad othar traumatic ev	2	19a. Informant's Name/Relationship (7	уре, Print)	19b. Mailir	ng Address (Street		r Rural Route Numbe	er, City or Town,	State, Zip	Code)
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ă	al or after al Dira	Certification;	4 Homicide	building, etc. (Specify)			City or Tow	m, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of r	ny knowledge, death	occurred at the til	me, date and pla	ace, and due to the	cause(s) and ma	nner as sta	ated.
	tha H iin 24 tha F iplete	Medical	one)	and manner stated	d.						
	viil to	2	29b. Signature and title of certifier	B-21		29c. Licens	c () 1 ~	C	29d. Date signed	(Month, C	vay, Year)
7	/			0		DC	t 64)	8	1.9	1,00	
	り		30. Name and address of person who d	ompleted cause of deat	n (Item 23a) (Type, I	Print)	the v	el # 30	2 011	nto-	~m122073
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	20000	(11)	CI - TI 30	11-00	ilor	11/1/4-15
	Registr	_	uu 9 Q .	anna base	and the	1 600	11				

			For	State of Marylar	nd / Dep	artment of H	lealth and	Mental Hy	giene	00000
			1 - State Registrar		Ce	rtificate of	Death		Reg. No. 1	23960
п	Physici	an	Decedent's Name (First, Middle,		C			2. Date of De Month	Day Year	3. Time of Death
	/Medio	cal	4a. Facility Name (If not institution,	tram Jac	Mson	4b. City, Town, o	or Location of De	July	26 2004 4c. County of Dec	
	Examir	ner •	Bon Secours	Hose! Hal		Balty	MANR	City	NIC	···
	Funeral			Sex 7. Age (In yrs.	,	If Under 1 Year Months Days	If Under 24 H		th 9. Bi	rthplace (State or Foreign country)
	Director		218 60 4341	2□F 19	Yrs.	Monard Days	1.00.0	Septemb	EL 96, 1954	M.D
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or L	ocation				10d. Inside City Limits
	Mary a-f sh	tor	MD N/C		BA Hin	IURE				1 Ves 2 No
	ith the Marylar or 28a-f show	Direc	10e. Street and Number	1		10f. Zip Code			10g. Citizen of What C	
	s 23a	eral	1829 W. KAN	12. Was Decedent Ever in U	S 12	212		(Specify Yes or No	- 14. Race - Am	
10	fter de r Item Inver	Funeral Director	11. Marital Status 1 Never Married 2 Marrie	Armed Forces?		If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)	Black, Wh	
036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show disal Everitive Fruithed at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 Z No	Specify:		Specify:	lacic
21215-0036	72 hours after death w "naturel", or Items 23a edical Exertine Frast B	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	nation during most of v	vorking	16b. Kind of Busines	s/Industry
121	within lene. than "	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	,	INTENANCE	MAN		NURSING H	cons
	other vent, I	BeC	17. Father's Name (First, Middle, La	ist)	777	70,000	18. Mother's N	lame (First, Middle	, Maiden Surhame)	
ylar	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, Its M	ToE	Claire JAK	512				SE HA	Bohop	
Maryland	12 shows and 7 le mu		19a. Informant's Name/Relationship		19b. Maili	1			er, City or Town, State,	
_	s 1 and of Health item 27 other tr		20a. Method of Disposition	20b. I		osition (Name of	worle st	Date	20c. Location - City o	
nor	ages ant of nt: If it y or o		Burial 2 Cremation 3	Hemoval from State		Matory or other pla	Ce) 8	/2/01	Baltoness	MA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "naturel", or items 23a or 28a-s show any injury or other treumatic event, it a Medical Exercited in a large and once.		21 Signature of Funeral Service Li		2	2. Name and Addre	ess of Facility	BENS Sun	Baltiming	
ä	Depar Depar Impor any ir		Totacio L	rub	11	29 N CA	neine Si		nang MD 218	13
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caused the dea nly one cause on each line.				iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. LUNG		ANCE	CR			
	Examiner			Due to (or as a consec	(uence or).					
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):					
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):					
8760,	eath certificate be executed attending physician and for use as the burial-transit	cal E		d	, , , , , , , , , , , , , , , , , , , ,					
9	tificate ig phy as the									
Вох	ith cer itendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	al death 3[⊒Ectopic pregnanc	y		23d. Date of de Month	blivery Day Year
o.	D 00 D	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of o	leath 5[Other (specify)				-,
۵.	requires that the een signed by th hould be detache	y Ph	Part II. Dther significant condition	s contributing to death but not res	sulting in the u	ınderlying cause gıv	ven in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
Records,	w require: been sig should b	Completed by	DIABET	-67				18	Yes 2□No 3□F	robably 4 Unknown
ecc	aw 2 si	pie						24a. Was	psy prior to	utopsy findings available completion of cause of
al H	Thate pag							1 ☐ Yes		s 2 No
Vital	Physician: The I this certificate har ral director, page	To Be	25. Was case referred to medical examinat? 1 ✓ Yes 2 ☐ No	Hospital: 1 Inpatient 2	EB/Outnatie	nt 3 DOA Ott	200	eath (Check only on Home 5 ☐ Resi	one) dence 6 □Other (Sp.	ecify)
J of	ding Phys		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				how injury occurred	Joney
sior	Attending r death. ector: After by the fune	catio	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion		M 1	Yes 2□No			
Division	or Att	Certification:	4 Homicide determin	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st fy)	reet, factory, office		28f. Location (City or To	Street and Number or F wn, State)	Rura i Houte Number,
	spital	alC	29a. Certifier 1 Certifying	Physician: To the best of my known	owiedge, dear	th occurred at the til	me, date and pla	ice, and due to the	cause(s) and manner a	s stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Ex	caminer: On the basis of examina and manner stated.	ation and/or ir	vestigation, in my o	opinion, death or	ccurred at the time,		
	with To t	Σ	29b. Signature and title of certifier	Main -		29c. Licens	se number	2	29d. Date signed (Mon	th, Day, Year)
	2		30. Name and address of person w	no completed cause of death /lice	n 23a) /Tuno	Print)	171.	5	July de	,
	σ		EDWARD BO	LIGGANO 1	1 D	200	OW	PACTI	MORE	1
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					
	Regist	rar	JHI 2.9	2001 /	K A	made 1				

DHMH 17 Rev 1/2001

3

State

29b. Signature and title of certifier

31. Date filed (Month)

LING. LI

JUL 2

w.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

To the

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 26, 2004

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death. 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 13:30 PM 25 900H terman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs.
Hours Min. -01101 2404 nawnee INKS DUNO 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 2 M 2 □ F **Funeral** Months Days Yrs. 235-22-751 Usual Residence of Decedent 80 Feb. 5, 1924 Director West Virginia the Maryland 10d. Inside City Limits r 28e-f ahow 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2X No Director Maryland Carroll Finksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö the Medical Examiner must be items 23a 21048 United States 2404 Shawnee Drive Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status e filed within 72 hours after of Hygiene." natural; or ite 1 XYes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 Married WWII Baltimore, Maryland 21215-0020 1 ☐ Yes 2 A No Specify. Specify: It Yes, Give Year or Dates: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture 10th Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be fill.
Department of Health and Mentel Hy
Important: If item 27 is merked oth
eny Injury or other traumetic even Be William Keller Myrtle Kinney P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2404 Shawnee Drive Finksburg, MD 21048 Alice Emma Keller Wife 20b. Place of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State South Carroll Crematory July 29, 2004 Winfield, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA 21. Signature of Funeral Service Licensee alles 1212 W. Old Liberty Road Winfield, MD 21784 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical rediate Cause (Final 2 4 KS disease or condition resulting in death)) EMENTI **Examiner** Due to (or as a consequence of) Examiner ettending physician end I for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resuming in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 The law requires that the death certificete be Physiclan/Medlcal Due to (or as a cons *quence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings certificate has been sir irector, page 2 should? 24a. Was an autopsy Completed available prior to completion of cause of death? 1 🗆 Yes 2×100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral c Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 27. Manner of Death After Natural 5 Pending investigation death. 1 Tyes 2 No 2 Accident or Attend efter death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Greene St. Battimore

MD 21201

DHMH 16 Rev 6/95

State

Registrar

Snou

2004

31. Date filed (Month, Day, Year)

JUL 29

mD

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 9 2004

32. Registrar's Signature

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of He rtificate of D			ne .No.2004	23964
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Catherine G 4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	07	4c. County of Deat	_
	Examin	er	Anne Arundel Medic			Annapo			Anne Ar	
5. 8.38	Funeral		Social Security Number 6. S		e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign
	Director		212-28-9455	□ M 2 🔀 F	73 Yrs.	Months Days	Hours Min.	Sep. 27,		ryland
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
	l sho	ō								1 ☐ Yes 2 ☐ No
	28a-1	rect	Maryland Anne Anne Anne Anne Anne Anne Anne An	rundel	Severn	10f. Zip Code		10g	. Citizen of What Co	ountry?
	3a or	D	1388 Trysty Frie	end Place		211	44	U	nited Sta	tes
99	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be molified at or other traumatic event, the Medical Examinar must be molified at	/ Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 2X	No	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
-003	hours itural',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual Occupa	ition	16	b. Kind of Business	
21215-0036	2 should be filed within 72 and Mental Hygiene. is marked other than "ne raumatic event, the Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12) 12		ife.	kind of work done d DO NOT use retired) maker	uring most of worki		Own Home	ŕ
b	I Hygie other	BeC	17. Father's Name (First, Middle, Last)		, 200		18. Mother's Name	(First, Middle, Ma	iden Sumame)	
Maryland	Mental Merital arked o	To B	Lilburn Hensley				Ila Hu	ighes		
lan	2 should and Men is marke aumatic	1	19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address (Street a	nd Number or Rum	il Route Number, C	ity or Town, State, 2	Zip Code)
	1 and 2 Health tem 27 i		Charles W. Keyton	, Sr Sp	ouse 1388	Trysty F				and 21144
Jore	Pages 1 nent of H ant: If ite ury or oft		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery, crea	matory or other place	9)		c. Location - City or	
Baltimore,	permit. Page: Department o Important: If any injury or once.		21. Signature of Funeral Service Licen		Meadowrid Ga	Name and Addres	s of Facility Eman Fune	eral Home	lkridge, 1 At MMP.,	Inc.
	40264	11 /	23a Part Enter the disease or com	nlications that caused	12	50 Washin	gton Blvc	i. Elkric	dge, Mary	land 21075 Approximate
	Physician /Medical		23a. Part 1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	. Sept		ock.			,	Interval Between Onset and Death
	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
	uted Insit	Examiner	cause. Enter Uniderlying Cause (Disease or injury that initiated events							
o,	exection and and rial-tra	Exa	resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate be executed physicien and the burial-transit	dicai		d						
9		0	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of de	iver.
P.O. Box	The law requires that the death certifules has been signed by the attending rage 2 should be detached for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
	s that ned b e deta	y P	Part II. Other significant conditions of	_		inderlying cause give	on in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ıd	w require been sig should b	led b	alcoholic	cirrho	0315.			1 🗆 Yes	2 2No 3 □ P	robably 4 Unknown
Records,	nysician: The law re his certificate has be I director, page 2 sho	omple						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical examiner?					(Check only one)		
of	Physician: this certificated and director,	မ	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatio			4 Nursing Ho		e 6 Other (Spe	cify)
Z C	ing inel	ion:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time o lnjury	Work	rat :? Yes 2 □No	28d. Describe how	injury occurred	
Division	Attending r death. ector: After you the fune	ficat	2 Accident investigation 3 Suicide 6 Could not b	e Zee Blees of Inc	jury - At home, farm, st				et and Number or Ri	ural Route Number,
οį	allor after I Dire	Certification:	4 Homicide	building, et	c. (Specify)			City or Town, S	State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical C			of my knowledge, deat of examination and/or in ated.					
	To the To the Comp	Me	29b. Signature and (le of certifier	6/2		29c. License	_	29d	. Date signed (Mont	h, Day, Year)
			Stephine	Ley	mD.	ν3	8510		07/27	104
_	Û	Į i	AAMC	Annax	death (Item 23a) (Type)	Print) UD 2	1401			7.2. 12.1.
	St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 2 9 2	. 7	rar's Signature	Spark	2			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2006 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 ☐ M 2 🕶 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show The Medical Extra ir er must be notified at 1 Yes 2 □ No Be Completed by Funeral Director MD. 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int. If Itam 27 Ia marked othar than "natural", or Items 23 Was Decedent E Armed Forces? 1 Yes 2 N Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Caban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname 19b. Mailing Address (Street and Number or 20b. Place of Disposition (Name of cametery, cramatory or other place) nod of Disposition Burial 2 Cremation permit. Pages 1 Department of H Important: If its any injury or ot once. 1 D Burial 3 Pemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heal dailure. List only one cause on sain line. Kandallatuwn, MD 21132 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) s been signed by the should be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Donknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No certificate 1 ☐ Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ⊋No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident within 24 hours after death To tha Funaral Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signative and title of certifier 29c, License number 53593

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

7505

Drive Baltimore

			State of Mar	•	artment of H			2001	22000
	0		Registrar 1. Decedent's Name (First, Middle, Last)	061	uncate of L	Jean	Reg. 2. Date of Death	12.	3. Time of Death
	Physici: /Medic		JAMES E. LYONS				07. 25 - 2	2004 Year	8:50 PM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of Deat	h
-			JOSEPH RITCHIE HOSPICS	In yrs. last birthday)	BALTIM If Under 1 Year	ORE If Under 24 Hrs.	8. Date of Birth	N/A	hplace (State or Foreign
	Funeral Director			70 Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ar) Co	VA
			Usual Residence of Decedent				05 AU . 1		
	larylan show	7		Oc. City, Town or Lo BALTIMOR					10d. Inside City Limits 1 Yes 2 No
	the Mi 28a-1	recto	MD NA	DALINOUR	حـات 10f. Zip Code		10g.	Citizen of What Co	untry?
	ath with the Maryla 23a or 28a-1 showes	io le	183 LINNARD ST.		21229	7		USA	
	ler deat	Funeral Director	11. Marital Status 12. Was Decedent Ev. Armed Forces?	er in U.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spanic Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	ours after des al', or Itams Extrojiner to	by Ft	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Mo 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	1 ☐ Yes 2 No	Specify:		Specify: BU	MOR
8	72 hour natural	ted t	15. Decedent's Education	16a. Decec	tent's Usual Occupa	ation		. Kind of Business/	
215	filed within 72 hours after death with the Maryland Hygiene. thar then "naturel", or Itams 23a or 28a-1 show ant, the Medical Exertifier is used the notified.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. L	kind of work done of DO NOT use retired)		FREIGHT	
121	e filed w ti Hygier othar ti vant, th		17. Father's Name (First, Middle, Last)	TIRACIO	R TRAILC		e (First, Middle, Maid	1,000	
Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg itam 27 is marked otha other traumatic avant,	To Be	JACOB LYONS				TOCHUS		
ary	2 should be and Mental is marked c		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a		al Route Number, Cit	ty or Town, State, Z	(ip Code)
	Health tam 27 i		COLLEANER LYONS	183 L 20b. Place of Dispo-	LINNARD OF	SIREET	1	MD. 21.	229
Jore	Pages 1 nent of Ho int: If itan		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	cemetery, cren	natory or other place	9)		LUREL , A	
Baltimore,	그 든 본 글		* 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	22	Name and Addres	is of Facility			40
ä	permi Depa Impo eny it		Wangh C	ya Si	ИВНИ С. С 51 ВАИО.	NATL' PIK		MD 212	29
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	2 cancer	with,	netasta	525		years
	Examiner		Due to (or as a d	consequence of):					1
5		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):					
00	ecuted and transi	Examiner	Cause (Disease or injury that initiated events c.						
\$ 50,	ate be executed hysician and the burial-transit		Due to (of as a t	consequence of):					
\$	ate hy:	edical	0.						
XO	leath certifica attending ph i for use as ti	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2		Ectopic pregnancy			23d. Date of deli	very Day Year
0.E	Physician: The law requires that the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as	by Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown 4 Pregnant at tir	ne of death 5 □	Other (specify)			1001111	54 ,
Na.	that the detected	y Ph	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
rds	w requires to been significations and significations are significations.						1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Conknown
7 Recd	faw reas bee	Completed					24a. Was an autopsy	prior to d	topsy findings available completion of cause of
E.	an: The l tificate ha tor, page	Con					performed 1 ☐ Yes 2 🗹		2 DNo
eMS of Vital	sician: Th certificate rector, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatien	ot 3 DOA Othe	ar	h <i>(Check only one)</i> nme 5 ☐ Residence	6 Other (Spec	Harrica
	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury				28d. Describe how in		WALCSPICE
٦, ١	tanding leath. tor; After the funer	atio	2 Accident investigation		M 1 🗆 '	Yes 2 □ No			
Nes Ly Division	f or Attandi after death. Diractor: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Street City or Town, St		ıral Route Number,
AMRS	othe Hospital or Attanding ilthin 24 hours after death. o tha Funaral Diractor: Alter ompletely filled in by the fune	al Ce	29a. Certifier Certifying Physician: To the best of	my knowledge, death	n occurred at the tim	ne, date and place,	and due to the cause	e(s) and manner as	stated.
700	To the Hospita within 24 hours To the Funaral completely filled	edical	(Check only 2 Medical Examiner: On the basis of e one) and manner state	xamination and/or inv id.					
	S this man	Σ	29b. Signature and title of certifier		29c. License	number	29d.	Date signed (Month	n, Day, Year)
	/		30. Name and address of person who completed cause of dea	ath (Item 23a) (Turn	1)20 Print)	+170	Ju	y 26, 20	004
	9		E. Tso MD Richey Hospic	£ 838	N. Euta	~ ST 13	Salfimore	MD	21201
:	Sta		31. Date filed (Month, Day, Year) 32. Registrar	s Signature	Sparks	/			
	Regist	ar	JUL 2 9 2004 Della	/ /	1 1				

Patient Known as: Carolyn Lamp

			Please T						-	Are Legible.	
			For	State of Ma	aryland	•			ental Hy	giene	00000
			State Registrar			Certifica	ite of De		2. Date of Dea	Reg. No.	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last) Carolyn A. Lar						Month	Day Year	4 6:00 PM
>	/Medic		4a. Facility Name (If not institution, give			4b. Cit	v. Town, or Lo	ocation of Death	July	4c. County of Deal	1
	Examin	er	Sinai Hospit	al of F	Saltin	ו פורת	301-	timble	- City	N/A	
	Funeral		5. Social Security Number 6. Sex		e (In yrs. lasi	birthday) If Und		f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h 9. Birt	hplace (State or Foreign
	Director		212-32-9307]M 2 ∏ F	68_	Yrs.	S Days	riodis iviit.			ryland
	and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Location					10d. Inside City Limits
	Maryl t sho	jo	MD Baltimo	re	Ki	ngsvil	ما				1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number) <u> </u>	1(2		Zip Code			10g. Citizen of What Co	puntry?
	death with the Maryland ims 23a or 28a-f show	al D	9 Bellman Court				21	1087		USA	
	ems a	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec	cedent of Hisp pecify Cuban,	panic Origin? (Spec Mexican, Puerto F	cify Yes or No- Rican, etc.)	- 14. Race - Ame Black, Whit	
ဝ	hours after turel', or ite	by Ft	1 Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give	No	1 ☐ Yes	2 No	Specify:		Specify: Wh	nite
212-003p	within 72 hours after death with the Marylar iene. r than "neturel", or items 23s or 28a-f show the Medical Evertinet mast be rediffed at	ed b	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates:	1	6a. Decedent's U		on.	1	16b. Kind of Business	Industry
Ç	within 72 ene. than "nel	Completed	(Specify only highest grad	e completed) College (1-4or 5		(Give kind of life. DO NOT	work done dur	ring most of workin	g	-	,
7	filed with Hygiene. other than	mo:	Elementary/Secondary (0-12) 12	0		eneral Man	ager of	Army Lodgi	ng	Army	
2		Be (17. Father's Name (First, Middle, Last)				18	8. Mother's Name	(First, Middle,	Maiden Sumame)	
yland	should be nd Mental rmarkad o	2	Stanley Schul					Elizabe			
Mar	O 60 50 00		19a. Informant's Name/Relationship (Ty							er, City or Town, State, I	NAME OF THE PARTY
a)	1 an Heal em 3		Angela D. Hess, 20a. Method of Disposition	daughte	20b. Plac	e of Disposition (A	lame of	ourt Kir	ngsvil _{ate}	Le, MD 2 20c. Location - City or	1087 Town, State
2	9 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		etery, crematory`d co Crema		7/24/	101	Baltimore	MD
Baitimor	그 후 후 그		21. Signature of Fund Service Licens		, riecz	22. Name	and Address	of Facility		44550	
ñ	permit. Departimport any inj		A STATE OF THE PROPERTY OF THE	Litte		E.F.	Lass	ahn Fune	ral Home	P.A. Kingsy	Belair Road Fille, MD 21081
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each li	d the death.						Approximate Interval Between
	Physician ¹		Immediate Cause (Final disease or condition	. Chro	onic.	Obstr	ucti	re Pulv	nonar	y Diseas	e 10 4rs
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):					,
	LAGITITIO	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequer	nce of):					
	lted nsit	Examiner	Cause (Disease or injury	555 15 (4.1 4.5							
,	be executed ician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):					
20				d							
9	death certificate e attending phys ed for use as the	by Physician/Medical	IF FEMALE:	791							
gox	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	ath 3 Ectopic				23d. Date of del Month	livery Day Year
	D 0 D	ysic	1 Yes 2 X No	4□Pregnant a 9□Unknown	t time of deat	h 5 ☐ Other	(specify)		-		
7.	The law requires that the site has been signed by the bage 2 should be detache	/ Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulti	ng in the underlyin	g cause given	in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ecords,	uires na sign lid be	d b	Pulmonar	y Fi	bro	sis			×	res 2 □ No 3 □ Pi	robably 4 Unknown
80	w requ	Completed	Congestiv	re Ite	art	- Fai	lure		24a. Was		utopsy findings available
r	The lav	omp	3			,	-		autor perfo	ormed? death?	completion of cause of
Vital		Be C	25. Was case referred to medical				2	26. Place of Death		-	
01 <	hysic his ce I dire	To	1 Hes SAINO	lospital: 1 Inpatio		VOutpatient 3		4 Nursing Hori		dence 6 ☐Other (Spe	cify)
	ing P	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Bb. Time of Injury	28c. Injury a Work?		8d. Describe I	now injury occurred	
<u>s</u>	death death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Ini	iury - At home	M e, farm, street, fac		es 2 No	8f. Location (5	Street and Number or Ri	ural Route Number.
DIVISION	lor A after Direction by	Certification;	4 ☐ Homicide determined	building, et	c. (Specily)	, , , , , , , , , , , , , , , , , , , ,	,		City or Tov		
	spite nours nerai / fillec									cause(s) and manner as	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner st					at the time,	date and place, and due	
	with Tot com	Σ	29b. Signature and title of certifier	,)	1	17	29c. License n	number		29d. Date signed (Mont	h, Day, Year)
			1 Jessa C	u-	- 101	12	KZS	5 -00		July 23	5 duy
	12		30. Name and address of person who c	ampleted cause of d		3a) (Type, Print)	i Has	Spital	of	Baltin	0,00
	Sta	te	31. Date filed (Month, Day, Year)		rar's Signatur	e 4	1	1		40	
	Regist		JUL 29	2004	repera	P	gyou				

			1 - For State Registrar	State of Ma		/ Depa		t of H	ealth a			_) 4	23968
	a		1. Decedent's Name (First, Middle, Last)	1							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		MARY CATHER	ZINE LI	USTER		,				JULY		1005	11:05 A M
Ì	Examin		4a. Facility Name (If not institution, give st.		-	1			Location o			4c. County	of Death	
			University of MARYL				If Under		If Under:		0.0-1(0:4)	N/A	0.0'4	1. (2)
С	Funeral Director		5. Social Security Number 6. Sex 1 1	M 21X7 F	e (In yrs. last 88	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day April 9	Year) 916	9. Birthi Cou	place (State or Foreign ntry) nnessee
			Usual Residence of Decedent									,		
	irylan ihow	_	10a. State 10b. County		10c. City, To									10d. Inside City Limits
	Se-fs	50	Maryland N/A		Ва	ltim								1 ☐ Yes 2 ☐ No
	filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or Items 23e or 28e-f show ant, It a Maclical Examirem matter mailfied at	Funeral Director	10e. Street and Number 134 South Schroede	r St.			10f. Zip	Code 223			1	og. Citizen of		ntry?
	eath 23	erai		2. Was Decedent I	Ever in U.S.	13.1			spanic Orig	nin? (Spe	ecify Yes or No-			can Indian,
10	r iten	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give		j.				, Puerto	ecify Yes or No- Rican, etc.)	Bla	ck, White,	etc.
21215-0036	ral', o	þ	3 ☐Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:			1□Yes 2	2.☑•No	Specify:			Specif	y: Wh	ıte
2-0	72 hc	Completed by	15. Decedent's Educa (Specify only highest grade	ation completed)	1	(Give	dent's Usua kind of wor	k done d	uring most	of worki	ng	16b. Kind of B	usiness/In	ndustry
2	vithin ne. han *	mpi	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. I	DO NOT us naker	e retired))			Orm Ha		
2	Hygie ther t nt.	ပိ	17. Father's Name (First, Middle, Last)			Homel	marci		18 Mothe	r's Name	(First, Middle,	Own Ho		
/land	Mental I	To Be	Samuel Luster								Luster			
Maryland	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural; or items 23e or 28e-f show amy injury or other traumatic avant. It a Modical Examinate in at the multifluid at angle.		19a. Informant's Name/Relationship (<i>Typ</i> : Jean Cole, daughte	e, Print) T	1	19b. Mailir 3702	ng Address 2 Fout	(Street a	nd Numbe S t .	r or Rura Balt	imore,]	r, City or Town,	State, Zij 225	o Code)
Baltimore,	ages 1 a nt of He : if itam or othe		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	moval from State	ceme	etery, crer	sition (Nam matory or of Crema	ther place		7 – 27		20c. Location		
틆	it. Partmet	19	* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	9	Бау	-	2. Name an				-04	Baltim	ore,	MD
Ba	Depring any ir	10	Rhen			1	Ambros	se Fu	ınera	1 Ho	me, Inc	• ^1	100	01007
	Pnysician /Medical	i v	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each lin	ne. ,: S	Do not ent							• MI)	Approximate Interval Between Onset and Death
	Examiner			Due to (or as	a consequen									I neck
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as										
	te be executed ysician and ie burial-transit	Examiner	triat iriitiated events	Conq	estive	HE	ART F	AIL	URE					
,092	e executana	EX	resulting in death) Last	Due to (or as-		,	1							
687	cate b	dical	d.	1110	CARDI	AL	INFA	IRCT	100					
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3□	Ectopic pro						te of deliventh	ery Day Year
<u>α</u>	w requires that been signed b should be dete	by	Part II. Other significant conditions cont	ributing to death b	ut not resultin	ig in the u	nderlying c	ause give	n in Part I.					he cause of death?
oro	requi	eted												bably 4 Unknown
I Records,	The la ate has page 2	Completed									24a. Was a autops perfori	ned?	Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					Other		of Death	(Check only on	10)		
of	Physi this c	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	spital: 1 Inpatie		Outpatier b. Time of	nt 3□ DO	- Accessor			me 5 ☐ Reside 28d. Describe ho			(y)
UQ	ding h. After funer	tion	1 XNatural 5 ☐ Pending	28a. Date of Injui (Month, Day	Y Year)	Injury	M	8c. Injury Work 1 □ 1	:? ∕es 2 🔲 I		zou. Describe no	ow injury occur	180	
Division	To tha Hospital or Attanding Physimitin 24 hours after death. To the Funaral Diractor: After this completely filled in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ury - At home c. (Specify)	, farm, str				-	28f. Location (St City or Town		er or Run	al Route Number,
	spltal ours a naral E	aj Ce	29a. Certifier 1 Certifying Physi	cian: To the best	of my knowle	dge, deat	h occurred	at the tim	e, date an	d place :	and due to the c	ause(s) and m	anner as s	stated.
	To the Hospitel of within 24 hours of Yo the Funeral D completely filled in	ledical	(Check only 2 Medical Examinations)	er: On the basis of and manner sta	examination	and/or in	vestigation,	in my op	inion, dea	th occurr	ed at the time, d	ate and place,	and due t	o the cause(s)
	To To	Σ	29b. Signature and title of certifier	۶			1 .		number		2	9d, Date signe		
•			30. Nam and address of person who	ple id cause of d	eath (Item 23	a) (Type,	Print)	4	649			July		
	1		RODERICK Kreist	seck m. D	. 22	South	GREE	お ど :	stract	B	altimose,	MARYLAI	ND S	1201
•	Sta Registi		31. Date filed (Month, Pay, Year) JUL 2 9 20	32. Registr	ar's Signature		9 4	ba	6					

			State of Maryland / Department of Health and M 1- State Amend Item 23a,25 per ME,G833,07/48/244bbDeath			
			Decedent's Name (First, Middle, Last),	2. Date of Death	2004	3. Time of Death
	Physici /Medic		Darlene Lewis		2 2004	1240pm
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	- 2	c. County of Death	•
-	Funeral		5. Social Security Number 6. Stx 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthp	lace (State or Foreign
	Director	2	17-82-3572 1 M 25 F 4 Yrs. Months Days Hours Min.	Month, Pay, Year	3 Mar	4/aux
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	Mary a-f sh	tor	MD Baltimore		i	Yes 2 No
	or 286	Director	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Cour	ntry?
	s 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	noity Van as No	14. Race - Americ	ean Indian
9	after d or itam	Funerai	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
5-0036	72 hours afler death with the Maryland natural', or Itams 23a or 28a-f show Jical Examilier must be traffiled at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: 3	2CK
-51:	in 72 n "nat	piete	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working the DO NOT use retired)	ng 16b.	Kind of Business/In	1.1
2121	filed within Hygiene. sther than "	Completed	Elementary/Sedgndary (0-12) College (1-4or 5+) NUTSe	Æ	ssisted	LIVING
pue	be file	Be	A	(First, Middle, Maide		0
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If itiam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic avent. The Medical Examiliar must be notified at	ူ (19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	Je Route Number, City	or Town, State, Zip	(Ode) 11
Ma	and 2 ; lealth ar m 27 is har trau	-	Tanika C. Lewis Daughter 4305 Connecticus	+Are 1	ot 103	MD2/229
ore	Pages 1 and of He int: If itam		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ate 20c.	ocation - City or To	wn, State
Baltimor	Pa Int		4 Donation 5 Other (Specify) A No Menoral Habb 6/2 21. Signature of Funeral Service Licensee	604 130	4tinge	MD
Ba	permit. Departri Imports any nju	S 11	Valle of Pulleral Service Liberises Valle of Control of	l De la	MD 31	210 2
1			23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List on the shock of heart failure.	r respiratory arrest,	100 21	Approximate Interval Between
	Physician	ì	Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		Due to fur is a consequence of):	(Stro	ko)	24/2
		Jer	Sequentially list conditions, Due to (or as a consequence of): Due to (or as a consequence of):	The Court	RC)	-110012
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease estimina)	//// ₁		24 hours
60,	be exe		resulting in death) Last Die to (or as a consequence of):	AND MEDICALE	XAMINEN	
68760,	tificate og phys as the	edicai	d.	PROVED BY MEDICALE		
Вох	eath certif attending for use a	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delive	,
O. E	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1		Month	Day Year
Ω.	that the de ned by the a detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
rds	w requires that s been signed t should be deta			1 ☐ Yes	2 No 3 Prob	ably 4. Unknown
Records,	law re las ber	Completed		24a. Was an autopsy	prior to cor	osy findings available
al R				performed? 1 ☐ Yes 2 ☐ N	death?	2No
of Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1	(Check only one) ne 5 ☐ Residence	6 Other (Specif	
	ng Physiter this		The state of the s	8d. Describe how inj		7
sioi	tandir leath. tor: Al the fu	catic	2 Accident investigation M 1 Yes 2 No			
Division	after of Direction by	Certification:	4 Homicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta		Route Number,
	ospita hours uneral ly filled		29a. Certifier (Check only Check only Check only Check only 2 Medical Examiner: On the basis of examination and/or investigation in my oning death occurred.	and due to the cause(s) and manner as st	ated.
	To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medicai	one) and manner stated.			
	Veitil Con	~	29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month, I	pay, rear)
			30. Name and address of per on who compled cause of death (Item 23a) (Typa, Print)		0/22	70
			H. Neal Reynolds, Bon Sprooms Hogoital 2000	west B	Altimor	e Street
	Sta Registi		31. Date filed (Month, Dal), Year) 32. Registrar's Signature JUL 2 8 2004			
		4.	LOUT PATER DE BOOK			

				State of Maryla		artment of F rtificate of			eg. No. 🤈 🧻	ΩI,	22070
	Physici		1. Decedent's Name (First, Middle, Last) Edna Virginia	Leatherman				2. Date of Dea Month July 25	Dav	Year	3. Time of Death
>	/Medie Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, or L	ocation of Death	4c. County		1. 1 Spik
	Funeral, Director		Riverview Care Ce 5. Social Security Number 220 22 2111 1 1	7. Age (In yrs	s. last birthday, 74 Yrs.	If Under 1 Year Months Days	Essex If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 08/30/1		9. Birthpi Count Tenr	Ce ace (State or Foreign fry) 1.
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Baltimor		ity, Town or L Roseda1					10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the Marylan 23e or 28e-f show ust be notified at	Funerai Director	10e. Street and Number 1509 Customs Rd.			10f. Zip Code 21237	7		0g. Citizen of V USA	What Count	ry?
020	after dea or items		11. Marital Status 1 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	U,S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - America ck, White, e :: Whi	etc.
Maryland 21215-0020	filed within 72 hours Hygiene. ther then "neturel", ent, the Medical Exa	To Be Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life. Wait)		pation during most of work d)		16b. Kind of Bu		
yland ;	d stal	To Be C	17. Father's Name (First, Middle, Last) Floyd E. Dotson				18. Mother's Nam Elizabe	e (First, Middle, I th Stewa		re)	
			19a. Informant's Name/Relationship (Type Donna Lee Sereno-W				and Number or Rur Rd Rose				Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a important: If item 27 is eny injury or other tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b. emoval from State	Place of Disp	osition (Name of matory or other plac Cemetery	ce)		20c. Location -	City or Tov	
Balt	permit. Departn imports eny injt		21. Signature of Funeral Service Control of Service	е		2. Name and Addre	ess of Facility CV&	ach/Rose Roseda			
>	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one limited in the control of the	End Stay	Je (or as a conse	sloshu c	tive P	or respiratory arm	y Dò	e91e	Approximate Interval Between Onset and Death Cum - Known
),	cate be executed physician and the burial-transit	ledicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	Due to	(or as a conse	quence of):					-
x 68760,	ertificate be ling physicia e as the bu		Cause (Disease or injury that initieted events resulting in death) Last	Due to (or as a consec	quence of):					
, P.O. Box	The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/N	Part II. Other significant conditions cont	(AD	sulting in the u	inderlying cause giv	ven in Part I. N Avvan	23b. Did to			the cause of deeth?
Division of Vital Records,	a law requires the best been signed as should be	Completed b	Shere Opt	le operoris	0			24a. Was a perform	n autopsy ned?	ava	re eutopsy findings ilable prior to npletion of cause leath?
Ta H			25. Was case referred to medical				26. Place of Deat	1 Ye		1 🗆	Yes 20 No
₹	Q 55 1	To Be	ovaminor?	ospital: 1 ☐ Inpatient 2 [☐ ER/Outpatie	nt 3 DDA Oth	or /	me 5 Reside		er (Specify,)
sion o	B	Certification:	27. Manner of Death Notural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	y et rk? Yes 2 □ No	28d. Describe ho			
Divi	To the Hospital or Attendin, within 24 hours after death. To the Funerel Director: Att completely filled in by the fur	Certifi	4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)			28f. Location (St City or Town	, State)		
	the Hosp in 24 hou the Funer ipletely fil	edicai	(Check only 2 Medical Exemine one)	clen: To the best of my kn er: On the basis of exemin and manner stated.	owledge, deat ation end/or in	vestigation, in my o	pinion, death occur	red at the time, di	ate and place, a	and due to	the cause(s)
•	D M M M M M M M M M M M M M M M M M M M	¥	29b. Signature end title of certifier	P .		D-	3 8 7.5	4 2	9d. Date signed $7-2$	(Month, E	2004 2004)-21221
	~		30. Neme and address of person who con MALIZA FIRD(em 23e) (Type,	Frint)	BASTE	RN 6	BLVD,	MO	1-21221
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** J_{uly}^{Month} 27, 2004 ar Michele Hubbard Molitano 12:05A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** Gilchrist Center Towson 8. Date of Birth (Month, Day, Year If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 【XF JUL 16, 441-58-0993 Yrs. 52 1952 Oklahoma Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location i Hygiene. other than "natural", or items 23s or 28e-f show vent, the Michael Examiner must be nutified at 1 ☐ Yes 2 XNo Ellicott City Maryland Howard Direct 10g. Citizen of What Country? 10e. Street and Number 21043 4702 Parkvale Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental H Kenneth George Hubbard Dorthy Louise Ranallo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 Is
any injury or other trau 4702 Parkvale Road Ellicott City, MD 21043
s of Disposition (Name of Date 20c. Location · City or Town, State Edward J. Molitano/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X remation 3 ☐ Removal from State Metro Crematory, Inc. 7/28/04 Baltimore, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Edward A. Gregorchik Cremation Society of MD, Inc. 299 Frederick Road Baltimore. MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OVarian 1eass Canco **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ussass or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 1€ months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) ed by the a P.0. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Jinknown 24a. Was an autopsy performed?
1 Yes 2000 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No 2 After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Atural 1 ☐ Yes 2 ☐ No death. 2 Accident after death | Director: ,d in by the f 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a

To the Funeral C

completely filled i 29a, Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 27 2004 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Prior) nouslos ST Baltimore was and term of Charles 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 9 2004 Registrar

Nolitaino

Michele Hubbard

Irma Miller

Physician

Examiner

/Medical

1. Decedent's Name (First, Middle, Last)

Dinai Hospital

Irma M. Miller

of

Baltimore

4a. Facility Name (If not institution, give street and number)

Baltimore (1)If Under 1 Year If Under 24 Hrs. 8. Divide of Birth (Month, Day, Year AUG 20, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Days Hours 80 215-12-7535 Yrs. 1923 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Be Completed by Funeral Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 S. Symington Avenue 21228 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other treumatic event QNRS. Kenneth Easter ပ Margaret Heil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Elder/Daughter 119 S. Symington Avenue Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 20c. Location - City or Town, State Springfield Cemetery 7/30/04 Sykesville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Liegnsee

Edward A. Gregorchik ²MacNabb^{es} Funeral Home, P.A. 301 Frederick Road Cátonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pulmonary /Medical Due to (or as a consequence of Examiner onnestive Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner to the Hospital or Attending Physicien: The law requires that the death certificate be executed as a consequence of) Box 68760 Completed by Physician/Medical the attending I IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural ospitar ...
4 hours after dea...
--arel Director; After the fire t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide v thin 24 hours a 29a. Certifier 1 🗸 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of centiler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17an JUL 2 9 32. Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Reg. No.

Day

Year

N/A

2004

4c. County of Death

10:00 A M

2 Date of Death

Month

		1- State of Maryland / Per in 6833 / Per in 6833	epartment of Health an Certificate of Death	d Mental Hyg	giene leg. Mg. () () (,	23973
Physici	an	1. Decedent's Name (First, Middle, Last) William	nurray	2. Date of Dea Month	ith Day Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D	July	24, 2004	8:30PM
Examir	ier	LEVINDALE NURSING HONE	BALTIMORE	eath	4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24	Ain (Month Day	9. Birth	place (State or Foreigr intry)
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town		12.21.	933	NC 10d. Inside City Limits
n the Maryland r 28a-f show	ctor	MO N/A BALTIN				1 Yes 2 No
th with th 23e or 26 ust be no	Funeral Director	10e. Street and Number 1332 CLEVELAND ST.	10f. Zip Code 21 230	1	0g. Citizen of What Cou	intry?
b after death with or Items 23e or	nera	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No-	14. Race - Ameri	
5-UU36 72 hours after death with the Maryland neturel; or Items 23e or 28a-f show disal Everpliner must be rodified at	by	Amad Forces? 1 Never Married 2 Married 1 Yes 2 Mo 1 Ye	If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 ⚠ No Specify:	uerto Rican, etc.)	Black, White	, etc. ACK
72 hours	eted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business/Ir	
withir lene.	Completed	_ Elementary/Secondary (0-12) College (1-4075+)	life. DO NOT use retired)	1.	FOOD SERI	VICE
be file d outh	o Be (17. Father's Name (First, Middle, Last) NURRAY		Name (First, Middle, M	Maiden Sumame)	
Maryland d 2 should be file th and Mental Hy to is marked oth treumetic event	ĭ		Mailing Address (Street and Number of		NATTERS City or Town, State, Zij	o Code)
re, Maryla s 1 and 2 should f Health and Men tiem 27 is marke other treumetic		20a. Method of Disposition 20b. Place of	Disposition (Name of	Date BALI	70. MO 2 20c. Location - City or T	1230
Saltimore, permit. Pages 1 a Department of Hea mportent: If item iny injury or othe		1 Burial 2 Cremation 3 Removal from State cemetery	r, crematory or other place)		BALTO. MO	OWII, State
Baltimore, permit. Pages 1 an Department of Heat Importent: If item 2 any injury or other		21. Signature of Funeral Service Licens	22. Name and Address of Facility VAUGHN C. GREE	NE FUNE		52a
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	of enter the mode of dying, such as care	diac or respiratory arre	est,	Approximate Interval Between Onset and Death
BOX 69/00, eath certificate be executed attending physician and for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classes in the year that initiated events resulting in death) Last b. Due to (or as a consequence of c. Due to (or as a consequence of d.				
law requires that the death certificates been signed by the attending of 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
wrequires that the deben signed by the should be detached	d by P!	Part II. Other significant conditions contributing to death but not resulting in			acco use contribute to the	
w requ	lete	peripheral Jascular diser		-		
DIVISION OT VITAL HECORDS, to attending Physician: The law requires the death. Director: After this certificate has been signe tin by the funeral director, page 2 should be on the death.	Completed by	diabetes nellitus, encephalo	, , ,	24a. Was ar autopsy perform 1 \(\text{Yes} \) 2	prior to condeath?	psy findings available mpletion of cause of 2 No
OI VITA Physician: r this certifica ral director,	b Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Monatient 2 ☐ FR/Outr		eath (Check only one		
g Phy g Phy er this	n: To	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injury at	g Home 5 ☐ Resider 28d. Describe how	nce 6 Other (Specify winjury occurred	y)
Attending at death. ector: After by the fune	atio	2 Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No	1		
ol or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fam building, etc. (Specify)	n, street, factory, office	28f. Location (Str. City or Town,	eet and Number or Rura , State)	l Route Number,
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely tilled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, 2 ☐ Medical Exeminer: On the basis of examination and/and manner stated.	death occurred at the time, date and pla or investigation, in my opinion, death oc	ace, and due to the car courred at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
Fo the within Fo the comple	Mec	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month.	Dav. Year)
->=0		> Maren & Balta, MID		76 =	July 25	2004
3		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)			
Sta Registra	te ar	31. Date filed (Month, Day, Year) JUL 2 9 2004 32. Registrar's Signature	Locate 1	-		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Samuel C. 26 2004 Julv 10:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Elizabeth Nursing Facility Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. Jan. 20, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**☆**M 2□F Months 77 Yrs Director 220-24-6788 1927 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show Exar dreer set be notified at 1 ☐ Yes 2√XNo Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 4216 Spring Avenue 21227 United States items 23a Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 □ Divorced "natural', other traumatic avant, the Mudical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Salvadore Marino Sarah Battaglia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or other tra Diane C. Winchester - Daughter 4216 Spring Avenue Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 7/29/04 Elkridge, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 Gary L. Kaufman Funeral Home 7250 Washington Blvd. Elkric 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death me Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last ding physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate No No 1 Yes funeral director. Be 25. Was case referred to medical examiner? 1 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 4 hours after death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) tha 29b. Signature and title of certifie 52746 Choice Core Golf name 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 720 mon dea BNIK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 9 2004 Registrar

			1 - For State Registrar	State of Marylar	nd / Depa	artment of Heartificate of De	lth and M	lental Hyg	_	1 000
			1. Decedent's Name (First, Middle, La.	st)		-		2. Date of Dea	_	3. Time of Death
п	Physici /Medi		Vivian	G.	McCr	arv		July 2	7, ^{Day} 2004	5:54 P ^M
7	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or Loc	ation of Death		4c. County of	
			Stella Maris			Timoniu	m		Bal	timore
	Funeral		5. Social Security Number 6. S		last birthday)	If Under 1 Year If U	Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
П	Director		254-42-9131	□ M 2□ X F 7!	5 Yrs.	Months Days H	ours Min.	(Month, Day Aug. 2	1928	Kentucky
	pu »		Usual Residence of Decedent 10a, State 10b, County	10-0						
	anyla shov	2	l constant,		ty, Town or Lo	cation				10d. Inside City Limits
	Ba-f	Sct	Maryland Baltimo	re Pi	hoenix					1 ☐ Yes 2 💢 No
	vith ti	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
	ath v	ā	13602 Blenheim Ro			21131			U.S.A.	
	er de	une	11. Marital Status	12. Was Decedent Ever in U Amed Forces?	l.S. 13.	Was Decedent of Hispar f Yes, specify Cuban, M	nic Origin? (Spe lexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:		I□Yes 2XX No Sp	оөсify:		Specify:	1.01.1.1
ô	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Examir at must be notified at		15. Decedent's Ed		100 Dane	landa Harat Carania				White
Ė	in 72	Completed	(Specify only highest gra	de completed)	(Give	lent's Usual Occupation kind of work done during DO NDT use retired)	g most of worki	ng	16b. Kind of Busi	ness/Industry
7	within ene. than "I	E E	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Execu		atany		Bankir	2.0
0	be filed within 72 hours after death with the Marylan ital Hygiene. bd other than "natural", or items 23a or 28a-1 show event, Itte Mardical Examinating must be notified at	ŭ	17. Father's Name (First, Middle, Last)	• • • • • • • • • • • • • • • • • • • •	LACCE			(First. Middle.	Maiden Sumame)	
an	id be ental ked c ev	To Be	Morris William	n Gorman			Marare	Dode I	l	
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked or any injury or other traumatic events.	-	19a. Informant's Name/Relationship (19b. Mailir	g Address (Street and N	Mary Number or Bura		lumphreys	
Ξ	ulth au 27 is r trau		Corey Branch	Son		Oak Ridge [Marylar	
ē	s 1 au í Hea ítem othe	11	20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of			20c. Location - Ci	
Baltimore,	age: ent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specify	Removal from State Du	laney V	alley Cardens	7 21 (
≣	artmoortar	1	21. Signature of Funeral Service Licen	En combinent 1	Memoria	L Gardens Name and Address of	7-31-2	2004	limoniun	n, Maryland al Home, Inc.
B	Depariming on in once.	d,	MILLER		1	050 York Ro	had To	ok iowst	n runera Naryland	21204
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	lications that caused the deat						Approximate
	Dhusisian		shock, or heart failure. List only					,		Interval 8etween Onset and Death
7	Physician /Medical		disease or condition resulting in death)	RENAL CELL Due to (or as a conseq						
	Examiner			Due to (of as a conseq	dence of).					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):		<u> </u>			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Uisease or injury that initiated events							
Ć	exec in an ial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	Attending Physician: The law requires that the death certificate be executed r death. refer this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Ical		d						
9	ifficat g phy as th	ed		-						
Вох	n cert andin use	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date o	of delivery
	death e atte	Icla	in the past 12 months? 1 □ Yes 2 XNo	1 Live birth 2 ☐ Feta 4 Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	
Ö	it the death certific by the attending p tached for use as	Physician/Med	9 🗌 Unknown	9□ Unknown						
ري ح	res tha igned be det	by P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the un	derlying cause given in l	Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
Records,	w require been sig should b	ed						1 ☐ Ye	s 2□No 3[Probably 4 Vunknown
00	aw re	Completed						24a. Was ar	24b. Wer	re autopsy findings available
Re	The tay te has age 2	E						autops	/ prio ned? dea	r to completion of cause of th?
tal	vician: Th certificate rector, pag	a	25. Was case referred to medical	21271			Dines of Death	1 ☐ Yes 2		Yes 2□No
Division of Vita	Attending Physician: The sr death. ector: After this certificate his by the funeral director, page	To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient			Check only one		Specify) HOSPICE
ō	g Phys er this eral di	i i	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?		8d. Describe ho	w injury occurred	Specify) HOSPICE
0	nding tth. r: Afte e fun	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	Work? M 1 ☐ Yes			. ,	
VIS.	Atte	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Injury - At no	me, farm, stre	et, factory, office	2	8f. Location (Str	eet and Number o	or Rural Route Number,
Ó	al or A s after il Direction by	Certification:	4 🗆 Monnicide	building, etc. (Specify	V)			City or Town	State)	
	pspit hours inera y fille		29a. Certifier X Certifying Phy	ysician: To the best of my kno	wledge, death	occurred at the time, da	ite and place, a	nd due to the ca	use(s) and manne	er as stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Madical Exam	inar: On the basis of examinat and manner stated.	tion and/or inv	estigation, in my opinion	, death occurre	d at the time, da	te and place, and	due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier			29c. License num	nber	29	d. Date signed (N	fonth, Day, Year)
	,			15-		Duz	771		7/28	104
	Ó		30. Name and address of person who d	completed cause of death (Item	23a) (Type, F		3		1/000	/ -7
	7		DR. TARIQ MAHMO				MONIUM_	MD 210	93	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signal						
	Registr	ar	1111 9 0 20	04 8	Lo 1	- 4				

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JULY 27, 2004

VIVIAN McCRARY

		_ 1	For State Registrar	State of Maryland		ment of Hicate of L			ene 3. No.2 () () ()	23976
	÷ .		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	_	EVELYN	MAY	es			5014	25 2004	(2:55 PM
	Examin		la. Fecility Name (If not institution, give	street and number)	4b	-	Location of Death		4c. County of Dea	th
		Bi		RATAN HOSP			LTIMORE		NA	
u Sign	Funeral Director		0160 4 0 410	7. Age (In yrs. la	Yrs.	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry)
	pur M	}	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	on				10d. Inside City Limits
	daryla	ō	Mr wal	^	DAI	-TIMOR	Ó			1 Ves 2 No
	the h	Director	10e. Street and Number		- 13	Of. Zip Code		10	g. Citizen of What C	ountry?
	3a or	0	5 LIGHT	ST.		2	1202		0.5	. A .
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13. Was	Decedent of Hi	ispanic Origin? (S) n, Mexican, Puert	pecify Yes or No-	14. Race - Am-	
136	be filed within 72 hours after death with the Maryland Hygiene. Hygiene dether then "natural; or Items 23a or 28e-f ehow dether then "natural; or Items 23a or 28e-f ehow event, the Medical Francisor must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		Yes 22 No	Specity:	7 110211, 010.7	Specify:	ih i Te
5-003	2 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Decedent	s Usual Occupa	ation during most of wor	kina 1	6b. Kind of Business	/Industry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO I	VOT use retired	()	5	Halafall	
1717	filed withi Hygiene. other ther ent, the N	Con	12+1	NIA		Homem		on (Final Middle 14	Home.	
ם	e d ia	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M	aiden Sumame)	
<u> </u>	should be and Mental I e marked o eumatic eve	ပ	Unknown	France Chaires	10h Madian A	ddaan /Straat		nown,	City or Tourn State	Zin Codol
-	0 - 0		19a. Informant's Name/Relationship (type, Print)	3423				City or Town, State, Ito Mo 2	
	1 and Health em 27 ther tr		20a. Method of Disposition	20b. Pl	ace of Dispositio	n (Name of		Date 2	Oc. Location - City or	Town, State
Baltimore,	Pages nent of I ont: If its ury or o		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	metery, cremato Celand		7/2		Balto. N	
	nt P	1	*4 □ Donation 5 □ Other (Specification 21, Schature 1 Funeral Service Licer		22. Na	ime and Addres				
g Ra	permit. Page Department of Importent: If any injury or once.		Vaul yn.	Stella					ecal Itome 21234	
P			23a. Parti. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not enter th	e mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
2	Physician		Immediate Cause (Final disease or condition	a.)	EP515					011001 0110 002111
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
	Examinet,	_	Sequentially list conditions,	b. Due to (or as a consequ	ence of):					
	ed sit	olne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0) 20 2 201 004 0	01100 01).					
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):					
8760,	cate be executed physician and the burial-transit	cal E		d						
687	ficate p phy ss the									
Box 6	leath certific attending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	ncy	opic pregnancy			23d. Date of de	livery
Ď	death e atte	icla	in the past 12 months?	4 Pregnant at time of de		her (specify)			Month	Day Year
P.O.	that the de ed by the a detached f	hys	9 Unknown	9□ Unknown						
ds, F	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buttal-transit	Completed by P	Part II. Other significant conditions of LCFT ARM	ontributing to death but not resu	Iting in the under	rlying cause giv	en in Part I.			o the cause of death? robably 4 ﷺ
OS	w req	lete	Gasto Intesti	in prest)			24a. Was an		utopsy findings available
Re	The lavie has	шо	C NO 10 Ph 1-7 La	15-15-0	,			autopsy perform 1 Yes 2	ed? death?	completion of cause of s 2 \sum No
ta	an: T	60	25. Was case referred to medical				26. Place of Dea	ath (Check only one		
<u> </u>	Physician: r this certific ral director.	To B	examiner? 1 ☐ Yes 2 🗭 No	Hospital: 1 Inpatient 2 1	ER/Outpatient	3□ DOA Oth	er: 4 Nursing H	lome 5 Resider	nce 6 Other (Spe	ecify)
0	ng Ph		27. Manner of Death 1 Natural 5 Pending	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury	28c. injun Wor	y at k?	28d. Describe how	w injury occurred	
Ö	Attending or death. ector: After by the fune	atle	2 Accident investigation			M 1 🗆	Yes 2 ☐ No			
Division of Vital Records,	after de Direct	Certification:	3 Suicide 6 Could not be determined			factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	lural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C		nysician: To the best of my knowniner: On the basis of examinat and manner stated.						
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
	F > F 0		DE NORTH	h MS		Y	RES 00	0	July 25	2004
	9		30. Name and address of person who	completed cause of death (Item	23a) (Type, Prin					
	1)		ROHINI NORO	NHA 5601	Loch R	Aven 1	BLVA. B	to Ho. Ms	21239	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signar	ture 4	1				

ORIGINAL

			1 - State of Marylar	-	artment of He			ne No O O I	ATTAL ATTAL SHAPE ABOVE
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Doris F. Marston 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L		2. Date of Death Month JULY	Day Year 26 200	
	Funeral Director		Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs 218−12−7994 1□ M 2√x F 80	. last birthday) Yrs.	Baltin If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y June 6,	ear) Co	hplace (State or Foreign unitry) ryland
	death with the Maryland ms 23a or 28a-f show froust be notified at	Director	Maryland N/A	Balti	more				10d. Inside City Limits 1√√√Yes 2 □ No
	ath with the 23a or 2	ral Dire	3939 Roland Avenue 812		10f. Zip Code 2121			. Citizen of What Co	
15-0036	hours after de: tural', or items al Examiner m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced 12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	'	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2☐xNo	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
0-61212	within 72 ene. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) embly Line	ıring most of worki	ng	b. Kind of Business	·
a		To Be C	17. Father's Name (First, Middle, Last) Arthur Clinedinst			18. Mother's Name	(First, Middle, Ma Lockner	iden Sumame)	
Ž	nd 2 sho lith and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print) Brian Dolan Son-in-law	9322	Oakwhite	Road Pe	rry Hall	, Maryland	1 21236
	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	esition (Name of matory or other place, 's Cemeter)		c.Location-City or	
Balt	permit. Departinimports any inju		21. Signature of Funeral Service Licensee	レ!	2. Name and Address Burgee—Her 3631 Falls	ss-Seitz Road, B	Funeral altimore,	Home, Ind Maryland	i. 21211
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse	ATOR	er the mode of dying,				Approximate Interval Between Onset and Death
8760,	the death certificate be executed y the attending physicien and ched for use as the burial-transit a	dical Examiner	Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. BILATERAL Due to (or as a consection of the control of	quence of j.	LOBE	PNEUMO	ONFA		5 DAIS CHRONIC
O. Box 6	at the death certific by the attending p tached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregress to 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
rds, P.		by	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause giver	s in Part I.			the cause of death?
al Records,	: The faw requires that cate has been signed b : page 2 should be deta	Completed					24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
Division of Vital	or Attanding Physician: Th ifter death. Diractor: After this certificate in by the funeral director, pag	ition; To Be	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Provided Pr	ER/Outpatier 28b. Time of Injury	other 3 DOA Other 28c. Injury : Work?	4 ☐ Nursing Horat	n (Check only one) me 5 Residence 28d. Describe how	e 6 Other (Special	cify)
Divisi		Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, str	reet, factory, office		28f. Location (Stree City or Town, S	at and Number or Ru State)	ral Route Number,
	To the Hospital within 24 hours a To tha Funaral I completely filled	Medical (29a. Certifier (Check only one) Check only one) Continuous Certifying Physician: To the best of my kn and manner stated.	nowledge, death nation and/or in	h occurred at the time vestigation, in my opi	nion, death occurr	ed at the time, date	and place, and due	to the cause(s)
1	with To	4	29b. Signature and title of certifier July 100 100 100 100 100 100 100 100 100 10	MD				Date signed (Monti	
1	Sta	ate -	30. Name and address of person who completed cause of death (lite FAHD AMTAD 301 EAST WAS 31. Date filed (Month, Day, Year) 32. Registrar's Sign	m 23a) (Type, VI VER nature	SITY PAK	WAY BY	OKIAL GLTIMOI	RE, MARY	AND 21218
•	Regist		31. Date filed (Month, Day Year) 9 200 32. Reg trar's Sign	, B.	Spark!				

			1 - For State Registrar	State of Maryl		artment rtificate			and M	•	giene Reg. No. 🤈 ʃ	106	230	70.
ı	Physici /Medi		Decedent's Name (First, Middle, Last) SCOTT		ELL, JR.		6.			2. Date of De Month July 2	Day	Year 4	3. Time of De 7:30P	ath U
7	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City,		Location o			4c. Cour	nty of Death	1	
		Н	Fort Washington Ho 5. Social Security Number 6. Sex	-	rs. last birthday)	Fort If Under		shing fUnder:			Princ	_		
	Funeral Director			M 2□F 83	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 11/15/	1920		nplace (State or Fo untry) tucky	>reign
	e Maryland la-f show	ctor	10a. State 10b. County Maryland Prince Geo	rania	City, Town or Lo		n						10d. Inside City L 1 ☐ Yes 🍇	
	vith th	Director	10e. Street and Number			10f. Zip		207	44		10g. Citizen o	f What Coi	untry?	
	eath v	erai	206 Aragona Drive	12. Was Decedent Ever in	nlis 13 t	Was Doord	ont of Hi			od. Van as Na	14 B		ione ladine	
920	urs atter d al', or Item	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No W If Yes, Give Year or Dates:	WII	Yes, special Yes 2			gin (Spec), Puerto F	cify Yes or No Rican, etc.)		ace - Amei lack, White city: Wh		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show shi njury or other traumatic event, the Medical Exerting must be rediffied at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed)	16a. Deced (Give life. Sales	dent's Usual kind of work DO NOT use Engi	l Occupa k done d e retired,	ation luring most	of workin		16b. Kind of		ndustry	
yland 2	vuld be filed Mental Hygi srked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Scott Mitchell,	Sr.							, Maiden Suma			
, Mar	and 2 sho ealth and n 27 is my		19a. Informant's Name/Relationship (Tyx Loudell Mitchell/W	ife	206	Argon	a Dr	rive I			er, City or Tow ton, MD			
Baltimore,	ges 1 it of Ho iff iter or oth		20a. Method of Disposition 1 ☐ Burial 2 黛Comation 3 ☐ Re	office and it office of the	b. Place of Dispo cemetery, cren					ate	20c. Location			
	artmen artmen ortant: injury		4 ☐ Donation ☐ Other (Specify) 21. Signature Funeral Service Licensé		Kalas Cr				7/27/		Edgewat as Fund	er,M	1.	_
Ba	Depre Impo		JANG. Kal	as h							as runa 11, Md.			
5	Physician /Medical		23a. Vart1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the decays on each line. Due to (or as a cons	. Kesa	er the mode	_	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Deat	th
46	Examiner	Iner	Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	F			,					une kno	Laur
	and errans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons		41						_	UN KN	203
8760,	icate be executed physician and the burial-transit	dicai	d	· · · · · · · · · · · · · · · · · · ·	A TO	[Je	pol	west	Dul	h- (Auce	-	une kinb	DWA
.O. Box 6	death certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etai death 3	Ectopic pre Other (spe						ate of deliv	ery Day Year	
rds, P	The law requires that the tee has been signed by the page 2 should be detached.	by	Part II. Other significant conditions conf	tributing to death but not	resulting in the ur	nderlying ca	use give	n in Part I.			obacco use cor res 2 No	ntribute to	the cause of death	
		Completed								24a. Was autop perfo 1 Yes	an 24b. esy rmed? 20 No	prior to co	opsy findings avail empletion of cause 2 No	iable of
	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?	ospital:			Othe	r		Check only o			777	
Division of	Attending Physician: If death. Sector: After this certification in the funeral director.	\vdash	27. Manner of Death 1 Natural 5 Pending investigation	28a. ate of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury		c. Injury Work	4 LI NUI	28		dence 6 🗆 Ot now injury occu		fy)	
Divis		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)					Bf. Location (S City or Tow	Street and Num vn, State)	iber or Run	al Route Number,	
	To the Hospital or within 24 hours after the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) Certifying Physical Examin	ician: To the best of my i er: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred a restigation, i	t the time	e, date and inion, death	d place, ar h occurred	nd due to the o	cause(s) and m date and place	nanner as s , and due t	stated. o the cause(s)	
\	To the complet	Ž	29b. Signature and title of certifier	K Olivou	M	29c.	License	unmpet	26 26	2	29d. Date sign	ed (Month,	Day, Year)	
	6		30. Name and address of person who cor Samuel Kleiman MD				t. W	ashin	gton	,MD. 20	0744			
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature &	In	a V	.,						

			Flea	State of M		epartment of h		-	•	•
			1 - For State Registrar	State of N	iaiyiaiiu / L	Certificate of		•	Reg. No.	22070
			Decedent's Name (First, Middle	, Last)				2. Date of De	ath	3. Time of Death
	Physic /Medi		Ruth N	Mack				Month	23.200°	1 4 3 - 1
	Examir		4a. Fecility Name (If not institution	give street and number)	4b. City, Town, o	or Location of Death	0 7	4c. County of De	
				ional Med		ter Sali	stury		Wico	nico
	Funeral		5. Social Security Number 214 12 1845	6. Sex 7. A	ge (In yrs. last bin	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Octobe	th Year) 1919 B	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	X 02	+			Joe Lobe.	r 9 1919 D	altimore,MD
	ryland how		10a. State 10b. County		10c. City, Town					10d. Inside City Limits
	ith the Marylar or 28a-f show	cto	Maryland Wicomico)	Salisbur					1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number			10f. Zip Code 21801			10g. Citizen of What	Country?
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heelth and Mental Hygiene. If itsm 27 is marked other than "natural", or flems 23a or 28a-f show or other treumatic event, the Modical Examina	Funeral Director	611 Tressler Drive	12. Was Deceden	Ever in U.S.		Hispanic Origin? (Sp	ecify Yes or No		merican Indian,
"	r Iter d	FE	1 Never Married 2 Marri	Armed Forces	?	13. Was Decedent of H		Rican, etc.)	Black, W	
21215-0036	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	white
5-0	72 hc	Completed by	15. Decedent (Specify only highes	's Education t grade completed)	16a.	Decedent's Usual Occup (Give kind of work done	during most of work	ring	16b. Kind of Busines	ss/Industry
121	within iene. than	m	Elementary/Secondary (0-12)	College (1-4or		`life. DO NOT use retire Sewife	nd)		Lla vacleografia	a. O to Homo
	filed Hygie other	ပိ	17. Father's Name (First, Middle,	Last)	IDU	Sewire	18. Mother's Name	e (First, Middle	Housekeepin	g-omi nuie
lan	Mental Mental arked o	To Be	Vermon A Smoot				Marie W	Schnitzle	ein	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the M	-	19a. Informant's Name/Relationsh	nip (Type, Print)	19b	Mailing Address (Street	and Number or Run	al Route Numb	er, City or Town, State	, Zip Code)
	and 2 selth a n 27 ls		Ronald J Mack				dale Drive	e Salis	sbury, Mary	land 21801
ore	of He of He if Itsm		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 ☐Removal from State	cemeter	Disposition (Name of y, crematory or other pla	ce)	Date	20c. Location - City	
Ë	Pages tment of tant: If It lighty or o		'4 ☐ Donation 5 ☐ Other (S	pecify)	Metro C	rematory Inc			Baltimore, Ma	ryland
Baltimore,	permit. Pages 1 and 2 Department of Heelth a Important: If Itsm 27 is any injury or other tre		21. Signature of Funeral Services	esch Ct	mek	Lassann Fune 7401 belair	iral Home In: Road Baltir	c nore,Marv	rland 21236	
	100		23a. Part1. Enter the dise so, or shock, or heart failure. List	complications that caus- only one cause on each	itb death. Do r	ot enter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· /	SYSTOL	6				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence				7	
	- Zammer	4	Sequentially list conditions,	b. ATHER	OSCUERA a consequence o		DVASCUL	AR	DISEASE.	
	ted nsit	Examiner	Sequentially list conditions, in any, reauming to immediate cause. Enter Underlying Cause (Disease or injury	330.073.0						
Ć,	le be executed ysician and e burial-transit	Exal	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):				
760,	w ~ w	cai		d						
. 68	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Med	IF FEMALE:							
Box	ath ce ttendi or use	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnanc	y		23d. Date of o	lelivery Day Year
	the a	ysic	1 □ Yes 2 No 9 □ Unknown	4☐Pregnant a 9☐Unknown	at time of death	5 Other (specify)				
P.0	that the ed by detact	Ph	Part II. Other significant condition	ns contributing to death	but not resulting in	the underlying cause giv	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Records,	uires that n slgned b	d b	PREUMONI	Α,				1 🗆 '	Yes 2□No 3□	Probably 4 Munknown
00	w requir s been s	iete	HYPERTENSI					24a. Was		autopsy findings available
Re	icien: The lav certificate hes rector, page 2	шо						autop perfo	rmed? death'	
Vital		Be C	25. Was case referred to medical				26. Place of Deatl			2420
of V	d is	2	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Ou	patient 3 DOA	ner: 4 Nursing Ho	me 5 Resi	dence 6 Other (Sp	pecify)
D C	ding P. J. After t funera	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da		ime of 28c. Injury Wor	rk?	28d. Describe I	how injury occurred	
Sio	Attending r death. ector: After by the fune	cat	2 Accident investig	ot be	ium. At homo fa		Yes 2 □No	29f Location /	Street and Number or	Pumi Pauta Numbar
Division	efter Direction by	Certification;	4 Homicide determine		tc. (Specify)	m, street, factory, office		City or To		Nural Fronte Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	aic	29a. Certifier 1 Certifyin	g Physician: To the best	of my knowledge	, death occurred at the til	me, date and place,	and due to the	cause(s) and manner	as stated.
	ne Ho ne Fu	Medicai	(Check only 2 Medical I	Exeminer: On the basis of and manner s	of examination and tated.	for investigation, in my of	opinion, death occurr	red at the time,	date and place, and d	ue to the cause(s)
	Vithing Vithing Comp	Σ	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
			Mahre	war !	N	10 D-	006051	15	7/231	24
	6		30. Name and address of person	who completed cause of		-			7	
	-		31. Date filed (Month, Day, Year)	APPA MD	rar's Signature (EASTERN		DA	SALISBUR	Y MD 2180.
	Sta Regista	_	JUL 2 9 20		والمراسم	sports	1			
						- "				

Registrar DHMH 17 Rev 1/2001

ST# 314-12-1845

Ruth Mack

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Ellen July 27 2004 11:10 PM Jane McIntyre /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Eastpoint Nursing Home Eastpoint Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 10,1930 9. Birthplece (State or Foreign Country) Baltimore, Md. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 F 74 218 26 6992 Director Usual Residence of Decedent with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Owings Mills Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "D" 1 Trolod Court Apt. 21117 USA death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mentai Hygiene. Int: If item 27 is marked other then "natural", or Ite 1 ☐ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: Specify White Completed by 3 ☐ Widowed 4 🎇 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be its Department of Health and Mental Himportant: If item 27 is marked of eny july or other traumatic evel once. Charles R. Sullivan Sr. Mabel Lebon L. ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 "C" Glenwood Road Essex Maryland 21221 Ellen Marie Moore (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory July 29,2004 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service License Bruzdzinski Funeral Home PA 22. Name and Address of Facility 1407 Old Eastern Avenue Essex Maryland 21221 23a. Fart1 Enter the dis shoot, or heart failu Immediate Cause (Final Enter the disease, or com, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest olications that caused the death. Approximate Interval Betw Onset and Death **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physicien and deed be detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal dea

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 ☐ Yes 2 ☐ No 3 Probably Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform After this certificate 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel 29a. Certifier 😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Qay, Year) of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 2. Date of Death . Decedent's Name (First, Middle, Last) Day Month Year **Physician** Robert S. Messaris 27 8:00 P M 2004 July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel 99 Rippling Ridge Road Glen Burnie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F 59 110-34-5038 5, 1944 New York **Director** Oct. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "neturel", or Iteme 23a or 28e-f show idical Examiner must be notified at 1 TYes 2X No Glen Burnie Maryland Anne Arundel Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21061 99 Rippling Ridge Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 GYes 2 No Army If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☼ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry treumatic event, the Medical al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Printing Journeyman Bookbinder 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental F is marked Pauline Laurie Joseph P. Messoris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a importent: If Item 27 is any injury or other tree once. 6 Woods Avenue Glen Burnie, Maryland 21061 Theresa A. Messaris - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July Date 30 20c. Location - City or Town, State 1 Barial 2 □ Cremation 3 □ Removal from State Crestlawn Mem. Gardens 2004 Marriottsville, Maryland 4 □ Denation 5 □ Other (Specify) 22, Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A. 21061
421 Crain Highway S.E. Glen Burnie, Maryland e of Foregal Service Licensee 100 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and the for use as the burial-transit The law requires that the deeth certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown ģ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy med? 2DNo certificate 1 Yes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat • Funerei Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1 Certifying Physician 2 Medical Exeminer: 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person why 180 Fan han sistrar's Signature 31. Date filed (Month, Day, Year) Registrar

			1 - For State Registrar	State of	Marylan		artmen rtificat			and Me	-	giene Reg. No	2001	23	982
	Physici	an	1. Decedent's Name (First, Middle, La	•							2. Date of Dea		y OO O Year	3. Time o	
*	/Medic		William L	. Mi							July		^y 2004 ^{Year}		8 A M
	Examin	er	4a. Fecility Name (If not institution, give		er)				Location of	of Death		40	. County of Dea		
			713 210th Stre		Age (In vrs.	last birthday)	If Under	asad 1 Year	ena If Under:	24 Hrs.	8. Date of Birt	th		Arundel	or Foreian
g d	Funeral Director			1⊠M 2□F	63	Yrs.	Months	Days	Hours	Min.	APR 1	y, Year)		rthplace (State Country) Dregon	
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside C	City Limits
	Mar e-f st	ctor	Maryland Anne A	rundel	Pas	sadena								1 TYes	2 ∑ No
	or 28	Director	10e. Street and Number				10f. Zip					10g. Ci	lizen of What C	Country?	
	ath w	ral	713 210th Str			0 1.0		211		1.0.40			USA		
9	be tiled within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23s or 28e-f show event, the Medical Examinar must be mailised at	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Deceded Armed Force 1 Tyes 2	es?		Was Deceo IIYes, speo 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spec i, Puerto R	cify Yes or No lican, etc.)	•	14. Race - Am Black, Wh Specify:		
8	ural',	d b	3 Widowed 4 Divorced	Year or Date	es:										
<u>7</u>	*nati	Completed by	15. Decedent's E (Specify only highest gr			16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation fu <i>ri</i> n <i>g m</i> osi)	t of working	g	16b. K	ind of Busines	s/Industry	
12	within ene. than	щ	Elementary/Secondary (0-12)	College (1-4 5+	or 5+)		uter		, ecial				Governm	nent	
9	Hygie other ent,	a	17. Father's Name (First, Middle, Las			Oomp	4 501				(First, Middle,			ICITE	
Maryland 21215-0036	should be ind Mental marked o	To B	Donald			Mixer				Viva			Web		
Jar	S as as		19a. Informant's Name/Relationship	(Typə, Print)		1		3 5					or Town, State,	Zip Code)	
	s 1 and f Health item 27 other tr		Donna Mixer 20a, Method of Disposition	spouse		713 Place of Dispo			reet	Pasa	dena Mi		122 ocation - City o	r Town State	
وّ	o to t		1 ☐ Burial 2 ☐ Cremation 3		ate (cemetery, crei	matory or o	ther plac	-	7/28/0					
Baltimore,	permit. Pag Department Important: I any Injury o		' 4 □ Donation 5 □ Other (Special Signature of Funeral Sepree 1)		met	ro Cre							timore	ome P.A.	
Ва	permit. Departm Importation any injuit	d e	bild 84										d 21122		•
>	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Str	ised the deal th line. OKES as a consec)	er the mod	e of dyin	g, such as	cardiac or	respiratory ar	rest,		Approxima Interval Be Onset and	tween
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and arial director, page 2 should be detached for use as the burial-transit or	dical Examiner	Saguentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Du οι c.	erco as a consec as nsec	mia	uble vera		ate len	Kem	ia			12 mo	ars
P.O. Box 6	that the death certificat ned by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		h 2 ☐ Feta nt at time of c	al death 3	□Ectopic pr □ Other (sp						23d. Date of de Month	elivery Day	Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions a strointes	1 0	th bul not res bleed	3	nderlying o	ause give	en in Part I.			obacco /es 2	_	to the cause of	death? Unknown
of Vital Records,	: The law requicate has been page 2 should	Completed	pneumonia										prior to death?		available cause of
'ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	ne)			
	ding After fune	၉	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		28b. Time o Injury		Bc. Injun	4 LI Nu		e 5 Resid		6 ☐Other (Spary occurred	ecify)	
Division	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not determined	be 28e. Place o	f Injury - At h , etc. <i>(Speci</i>	ome, farm, str	reet, factor	y, office		28	Bf. Location (S City or Tox	Street ar vn, State	nd Number or F	Rural Route Nur	nber,
	To the Hospital within 24 hours a To the Funerel I completely filled	edical (29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the base aminer: On the base and manne	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	ne, date an pinion, dea	d place, ar th occurre	nd due to the d at the time,	cause(s date an) and manner a d place, and du	as stated. le to the cause(s)
	To the within To the comple	×	29b. Signature and title of certifier	100	_		_	. License					te signed (Mor		1
	1		Illy El	Llli M			1	200	54	470	2	Ju	ly 27	, 2009	+
	5		30. Name and address of person who	completed cause	of death (Iter	m 23a) (Туре. ohns H	Print)	ns H	ospit	al, 6	00 N.	Wol	Fe. St. B	altimere	MD
	Sta Regist		31. Date filed (Worth, Day, Yoar)	9 2004 P			4	La	als	*					

13956		Chate of Manuford / Dane		•	•
		1- State of Maryland / Depa Registrar Amend Item 21 per FH, G833,07/29	riment of Health and Me Middle of Death	ental Hygier	18
	÷.	Registrar 1. Decedent's Name (First, Middle, Last)		Reg. P. 2. Date of Death	3. Time of Death
Physic					Day Year 15 2004 10:39 P
/Medi Exami		Erin Ashleigh Mercer 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	0 00 10	15 2004 10:39 P''' tc. County of Death
Cydilli	ıçı	Prince George's Hospital Center	Cheverly		Prince George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth	9. Birthplace (State or Foreign
Director		220-31-8800	F	eb.1,19	88 Virginia
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
Mary -f sh	tor	MD Prince Georges Fort Wast	ington		13X Yes 2 ☐ No
n the	Director	10e. Street and Number	10f. Zip Code 20744	10g. (Citizen of What Country?
15-0036 72 hours after death with the Maryland "natural" or items 23s or 28e-f show ledical Evanithat Triast be multihed at	aiD	7902 Den Meade Ave.	20744		USA
r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. W Armed Forces?	as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
36 s afte	by Fu	1 ★ Never Married 2 Married 1 Yes 2 No If Yes, Give 1 3 Widowed 4 Divorced Year or Dates:	☐ Yes 2 No Specify:		Specify: Black
21215-0036 ad within 72 hours af glene. ser than "natural", or t, the Medical Even.		15 Decedent's Education 16a, Decede	ent's Usual Occupation	16b.	Kind of Business/Industry
within 72 ene.	ompieted	(Specify only highest grade completed) (Give kife. D	ind of work done during most of working O NOT use retired)	7	•
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6 0 0 - L		1 Burial 2 □ Cremation 3 □ Removal from State cemetery, crem	atory or other place)		
		21. Signal of of Funeral Service Licensee Roser F. Mason 22.	tion Cem. 6/23/ Name and Address of Facilityree	2004 CI	inton, Maryland
Balt permit. Departit Imports any inj			4 Franklin St.,		
1		23a. Part1. Enter the disease, or complications that glused the death. Do not ente shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician		Immediate Cause (Final			Onset and Death
/Medical		resulting in death) Due to (or as a consequence of):	jures .		
Examiner		Sequentially list conditions, b			
led sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
and I-trar	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
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Box eath cert attending	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ I	Ectopic pregnancy		23d. Date of delivery
G. B deat he att	sicis	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
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Vital Record. siclen: The law require. certificate has been si	ompieted			-	
Aec e taw has t	mpi			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	O			1 X Yes 2□N	
of Vita Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? ↑☐ Yes 2☐ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient	26. Place of Death (6 □Other (Specify)
	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28	d. Describe how in	jury occurred
Division of Attending latter death. Director: After sin by the funer	Certification:	i Linatural 5 Feriding	P M 1 Tes 2 1 No 14	essenger =	vehicle shuch by
Divisional or Attendiss after death.	tific	3 Suicide 4 Homicide 6 Could not be determined 6 Homicide 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 28	f. Location (Street City or Town, Sta	and number or Hural Houte number,
Dital or	Cer	madia		- 214 west	of 12+193
Hospital or 24 hours afte Funeral Dir	edical	29a. Certifier (Check only (occurred at the time, date and place, an estigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
To the Hos within 24 ho To the Fun completely	Med	one) A and manner stated. 29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
Z × Z × S	1				
		Joshan Lely MD 30. Name and address of person who completed cause of death (Item 23a) (Type, P	O.C.M.E	. Ju	ne 16, 2004
1			Penn Street, Balt	imore. M	arvland 21201
S	tate	31. Date filed (Month, Day, Year) 32. Begistrar's Signature			
Regis	trar	JUL 2 9 2004 Senter &	rocks		

State of Maryland / Department of Health and Mental Hygiene Stete
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** July 21, 3:50 p Leona Gertrude Newman 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 3813 Elmcroft Road Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 28 F Yrs. 213-24-8202 74 02-02-1930 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, it s he show 1 Yes 2 No Director Baltimore Randallstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21133 U.S.A. 3813 Elmcroft Road Completed by Funeral death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. be filed within 72 hours after ontal Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be f Health and Menta Arthur Martin Ethel Wolfgang 2 Pages 1 and 2 should nent of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Husband) 3813 Elucroft Road Randallstown, Maryland 21133 Robert Newman 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1. Burial 2 □ Cremation 3 □ Removal from State 07/24/04 Baltimore, Maryland Woodlawn Cemetery * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors Inc 21. Signature of Funeral Service Licensee Moo 333 8728 Liberty Road Randallstown, Maryland 21133 Kallner 23a. Part Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cancer Physician uh resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٥ ō this 28b. Time of Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Natural Injury Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours aft To the Funeral Di completely filled in 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D15552 7/22/04 m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Ste 340 23 Crossvords Jaichtz, M.D_ 31. Date filed (Month, Day 32. Regia ar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 27, **Physician** 5:30 pM 2004 Ruth Elizabeth Newark /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Long View Nursing Home Manchester Carroll 8. Date of Birth (Month, Day, Year) June 1, 1901 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min. Months Days Hours 1 ☐ M 2 🖫 F 103 Yrs. 216-10-7512 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Reisterstown Director Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21136 309 Bryanstone Rd. Pages 1 and 2 should be filed within 72 hours after death value abelit hand Mohald Hygiene.
and: If item 27 is marked other than "natural", or items 23i and it item 27 is marked other than "natural", or other traumatic event, the Medical Examinat must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Accountant Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margaret McDonald Philip Germack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 309 Bryanstone Rd., Reisterstown, Md. 21146 Emma Lanocha - Friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Department of Importent: If any injury or once. Loudon Park Cem. July 30, 2004 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Eckhardt Funeral Chapel, P.A. 21117 21. Signature of Funeral 11605 Reisterstown Rd., Owings Mills, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medical attending I for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death ed by the a Records, P.O. 9 Unknown 9 Unknown signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 ☐ Probably 4 ☐ Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 2 No 1 Yes Division of Vital To the Hospitei or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient 2 this 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification; Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation completely filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sign tue and title of certifier Road, Westmins

State Registrar

JUL 2 9 2004

31. Date filed (Month, Day, Year)



				For Stata Registrar	State of Mary	land / De		lealth and M	lental Hygi	_	23986
		Physicia /Medic			owens				2. Date of Death Month	Day Year Zoo	
	-	Examin Funeral	er	5. Social Security Number 6. S	pital of	Ballm yrs. last birthda	or Bush	If Under 24 Hrs.	8. Date of Birth (Month, Day,	4c. County of Dea	thplace (State or Foreign
		Director		212-42 - 7653 Usual Residence of Decedent 10a. State 10b. County		63 Yrs.	Location		02 14	1941	10d. Inside City Limits
		death with the Maryland ms 23a or 28e-f show frount be mulfiled at	Director	MD N/A	10.00	BAL	TIMORE 101. Zip Code	21207	10	g. Citizen of What Co	1 X Yes 2 □ No
SW	9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Importent; If item 27 is marked other than "neturel", or Itams 23a or 28e-f show any injury or other treumetic event, If a Marical Examinational be multiled at ODGe.	y Funerai Director	4101 Rollins A 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	r in U.S.	3. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spi an, Mexican, Pueno	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian, te, etc.
3	21215-0036	hin 72 hours e. in "neturel', Maulcul Exe	Completed by	3 XWidowed 4 ☐ Divorced 15. Decedent's E (Specify only highest gr.	Year or Dates:) (Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retire	during most of work d)		6b. Kind of Business	/Industry
73	and 21;	be filed wit ntal Hygiene ed other the event, the	Be	17. Father's Name (First, Middle, Last	NA		Home	18. Mother's Name			
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7	Baltimore,	. Pages 1 a tment of Her tent; If item jury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)		position (Name of rematory or other pla	T D80	02/04	Baltim	ore, MD
	Bal	permit Depar Impor any in		21. Signature of Funeral Service Lice 23a. Part1. Entertable disease, or conshock, or heart failure. List only	V	e death. Do not	5151 BAL	TMORE N	JATIONA	L PIKE B	ALTO MD 2122 Approximate Interval Between
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	Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	livery Day Year
	rds, P.	equires that the second of the	ed by Ph	Part II. Other significant conditions hepotic erre	contributing to death but n	ot resulting in the	a underlying cause gr	ven in Part I.		acco use contribute to s 2 □ No 3 □ P	o the cause of death?
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	Σ Iξ	sicien certifi irector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2□ER/Outpa	tient 3 DOA Ott	har	h <i>(Check only one</i> ome 5 □ Beside	nce 6 □Other (Spe	acify)
	ion of	ath. ath. or: After this	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		e of 28c. Inju		28d. Describe ho	w injury occurred	
	Divis	oitel or Atteurs after de erel Directo	i Certification:	3 Suicide 6 Could not determined	28e. Place of Injury building, etc. (\$\frac{1}{2}\$	Specify)			City or Town		
		e Hosi 124 ho e Fune letely f	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	miner: On the basis of ex and manner stated	amination and/o	investigation, in my	opinion, death occur	red at the time, da	ite and place, and du	e to the cause(s)
•	}	To the within To the comp	Ž	29b. Signature and title of certifier	the		RE:	se number	29	July 27	th, Day, Year)
	-	Le		30. Name and address of person who	ruskn ?	Sinai	Hospital :	St Bellin	nore		
	Di	Regist		31. Date filed (Month, Day, Year) JUL 2 9 2004	32. Registrar's	Signature	se d.				
	υF	HMH 17 Rev 1/2	.001		/	ORIGIN	AL				V8505A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ELEANOR MAR PRETTYMAN Year Physician 955PM 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RITCHIE HOSPICE 15.4LTIMORE JOSEPH If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🕱 F 92 Yrs. 220-30-365 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event. The Medical Exercit at must be notified at MD BALTIMORE 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3506 SPRINGDALE AVENUE 21216 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: BACK 3 Novidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) POMOSTIC HOMEMAKER 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ould be f Mental ł ELEANDRE and Mental GEDREE MITCHELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2307 OCALA AVENUE BALTO MD Department of Health a Important: If item 27 Is any injury or other trains 000. LOUISE REED 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/29/04 BALTIMORE, MD BALTIMORE NATIONAL ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
VALIGHT C. GREENE FUNCKAL SERVICES 5151 BALTIMUKE NATIONAL PIKE BALTUMD 21229 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval tween one and a Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attanding physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, requires that the death cartificate be IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Uknown Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I rector, page 2 s autopsy performed 1 Yas 2 No 1 ☐ Yes 210 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 to ther (Specify) 1 Tyes this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manne of Death 28d. Describe how injury occurred Certification: After To the Hospital or Attanding 5 🗌 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 1/2001

State

30. Name and add

(Month, Day, Year)

JUL 2 9 2004

32. Registrar's S

			1 - For State Registrar		Marylar	nd / Depa	artmen rtificate					Reg. No	00		2391	8.8
	Physic		1. Decedent's Name (First, Middle, I Aaron C. Perkin	,							2, Date of D Month	Day		Year	3. Time of	
>	/Medi Examir		4a. Facility Name (If not institution, g		ber)		4b. City,	Town, or	Location of		July	23 4c.		04 of Death	3:45	A ^M
			Casey House				Rocky							omery		
	Funeral Director		5. Social Security Number 212–18–5983	Sex 1⊠M 2□F	7. Age (<i>In yr</i> s. 90	last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of B (Month, D Oct 28	irth Pa <i>y, Year)</i> R. 19	13	9. Birthp Coun Mary	iace (State o try) 1 and	r Foreign
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c Ci	ty, Town or Lo	reation				000 20	,, -,				
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	or 28a	Funeral Director	10e. Street and Number		1		10f. Zip	Code				10g. Cit	izen of \	What Coun	try?	
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036	nit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23e or 28e-f show injury or other traumatic avant, its Modical Examination injury or either traumatic avant.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	ces? 2 X No		was Deced f Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0-		e - Americ ck, White, c : B1a	etc.	
21215-0036	within 72 ho ane. t han "natu i	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		4or 5+)		kind of wor DO NOT us	k done d e retired)	tion unng most	t of worki	ing			usiness/Ind	,	
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ylar	Menta Menta arked atic av	To B	William Perkins						Ama	nda .	Austin					
Maryland	d 2 should the and 7 is mutant		19a. Informant's Name/Relationship Jacqueline Dorsey		ar)						l Route Numb				Code)	
ē,	f Heali itam 2 other		20a. Method of Disposition		20b. I	Place of Dispo	sition (Nam	a of	1		arksbui ^{late}			O8 / I City or To	wn, State	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec		Ga	rrison	Fores	st Ve	t. C	em.	7/27/20	04	Gar	rison	, MD	
Ball	permit. Departr Imports any inju		21. Signature of Funeral Service Lio	1/1/		Bu	. Name and	-Que	en Fu	inera	1 Home	and	Cre	mator	v. P.,	Α.
	_		23a. Part1. Enter the disease, or co	mplications that car	used the deat		12 We	st (IId_L:	iberi	ty Rd.	Winf	ielo	1, MD	21784 Approximate	
2	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition			c Carci	noma							6	Interval Betw Onset and D Month)eath
	/Medical Examiner		resulting in death)	Due to (o	ras a consec	(uence of):										
	cuted od	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	U	ras a conseq	e Cance quence of):	r							1.	5 Mont	hs
8760,7	icate be executed physician and s the burial-transit	licai	resulting in death) Last	Due to (o	r as a conseq	uence of):										
.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2∐Feta ntattimerofd	ıldeath 3⊡	Ectopic pre					2	23d. Date Mor	e of deliver	,	ear
۵.	ires that signed b d be deta	by PI	Part II. Other significant conditions	contributing to dea	ith but not res	ulting in the ur	nderlying ca	use givei	n in Part I.		23e. Did 1	tobacco us	se contr	ibute to the	e cause of de	eath?
ord	w require been sign should t	eted					-				1 🗆	Yes 21	No	3 Proba	ibly 4 □Ui	nknown
Division of Vital Records,	n: The law licate has b rr, page 2 sl	Completed							7		24a. Was auto perfo 1 Yes	psy ormed?	d	rior to com leath?	sy findings a pletion of ca	vailable use of
Ę.	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Ing	patient 2	ER/Outpatient	3 DO				(Check only one 5 ☐ Resi		Ho Othe	Spice	· Case	s'e
sion o	To the Hospital or Attanding Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	on	Injury Day Year)	28b. Time of Injury	28 M	lc. Injury Work	at ? es 2 □ N	2	8d. Describe	how injury	occurre	ed e		
D N	To the Hospital or Att within 24 hours after de To the Funeral Diract completely filled in by t		3 Suicide 6 Could not determine	d 289. Place o	, etc. (Specif						8f. Location (City or To	wn, State)				er,
	e Hospita 24 hours e Funeral etely filled	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medicel Exa	hysician: To the b miner: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, death	l place, a h <i>o</i> ccurre	nd due to the dat the time,	cause(s) a date and	and mar place, a	nner as sta nd due to t	ted. the cause(s)	
r	To the within To the comple	Me	29b. Signature and title of penifier	eik-		TD.		License						(Month, D		
,	31		30. Name and address of person who				•									
	Sta		Eugene P. Libre, I 31. Date filed (Month, Day, Year)	10400 32. Rec	Conne gistrar's Signa	ticut A	Ave. F	Kenns	singt	on,	MD 2089	95				
	Registr		JUL 2 9 2004	1 1		h	1	2								
DHI	MH 17 Rev 1/20	001				ORIGINA	L	2								

			State of Maryland / Department of Health 1- State Registrar Certificate of Death	and Ment		ne	22000
	Physicia /Medic	100	1. Decedent's Name <i>(First, Middle, Last)</i> Linda Ann Ruley		ate of Death	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locatio Union Memorial Hospital Baltimore			4c. County of Dea n/a	th
	Funeral Director		217 50 0636 1 M 2 F 59 Yrs. Months Days Hours	der 24 Hrs. s Min. 8. D	ate of Birth Month, Day Ye 27/1945	9. Bir Co Ma	thplace (State or Foreigr ountry) aryland
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County Baltimore 10c. City, Town or Location Rosedale	day.			10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	with the N Sa or 28a-	I Director	7509 Brightside Avenue	-	10g.	Citizen of What Co USA	ountry?
980	n 72 hours atter death with the Maryland "natural", or Items 23s or 28s-1 show "adjeal Examines, must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2X Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexic If Yes, Specify Cuban, Mexic If Yes, Sive Year or Dates:	can, Puerto Rican	res or No-	14. Race - Ame Black, Whit Specify: Whi	te, etc.
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 16a. Decedent's Usual Occupation (Give kind of work done during m iffe. DO NOT use retired) Home Maker	nost of working	16b	. Kind of Business Own Hon	
Maryland 21	be filed tal Hygi d other	To Be Col	17. Father's Name (First, Middle, Last) Charles Robert Hopkins	other's Name <i>(Fir</i> s Anna Pel	1ek	den Sumame)	
, Mar	s 1 and 2 should ! Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) Graham Riley Jr. HUSBAND 19b. Mailing Address (<i>Street and Num</i> 7509 Brightside	Avenue R	osedale	Marylar	nd 21237
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra ance.		20a. Method of Disposition 1	7/27/04	Ca	Location - City or	e MD.
Balt	permit. Departimporti sny inj		21. Signature of Funeral Service Licensee 22. Name and Address of Fact 1211 Chesaco At	^{cility} Cvach/ venue Ro	Rosedal sedale	e Funera Maryland	1 Home 1 21237
68760,		dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		piratory arrest,		Approximate Interval Between Onset and Death Uweeks Hweeks
P.O. Box 6	The law requires that the death certificate is the has been signed by the attending physioage 2 should be detached for use as the t	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 2 2 2 2 2 2 2 2			23d. Date of de Month	livery Day Year
	uires that signed b Id be deta	d by Pl	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Pa	int.	23e. Did tobacc 1 ☐ Yes		o the cause of death? robably 4 □Unknown
of Vital Records,	The law requir sate has been si page 2 should	Completed by	endstage renal disease		24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of 25X No
Vita	ysician: Th is certificate director, pag	To Be	examiner?	ace of Death (Che Nursing Home		6 □Other (Spe	ocify)
ion of	ng Ph Iter th Ineral		27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 1 Injury 28c. Injury at Work? 2 Accident investigation		Describe how in	ijury occurred	
Division	in Pitt o	edical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Street City or Town, St		ural Route Number,
	e Hospital	dical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date of examination and/or investigation, in my opinion, of and manner stated.				
	To the within 2 To the complete	¥	29b. Signature and title of certifier 29c. License number AT2 43	er 200 Lula	29d.	Date signed (Mont	th, Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	baltmore	· Mar	July 23	218
\$	Sta Regist		31. Date filed (Month, Day, Year) 9 2004 32. Registrar's Signature & Sparks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death . 05am **Physician** /Medical County of Death acility Name (If not institution, give street and number)

Principlov K Nussia 4b. City, Town, or Location of Death Examiner If Under 1 Year If Unde Social Security Nu 6. Sex 8. 9 Birthplace (State on For **Funeral** Days 1 M 2 F Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Germantown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 21 No Specify δ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hygiene. Importent: if item 27 is marked other then "na any injury or other traumatic event, the Media 2006. Elementary/Secondary (0-12) Mother's Name (First, Middle, Maiden Surnay 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition Name of cemetery, crematory or other place)

20b. Place of Disposition Name of cemetery, crematory or other place) 20a. Method of Disposition 1 D Burial 2 Cremation 3 Removal from State -,2-04 4 ☐ Donation 5 ☐ Other (Specify) Owings M Vaughnic 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Green Funeral Size. 8728 Liberty RD listown MD 21132 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 1 fore. List only one cause on each line. SEPSIS S Immediate Cause (Final disease or condition resulting in death) YNDROWF **Physician** /Medical Examiner PNEUMONTA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? ò 4☐Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by CEREBRO MSCULAR ACCIDENT, END STAGE LEWAL 1 Yes 2 No 3 Probably 4 □Unknown page 2 should DIABETES MELLINS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy MALNUTHINON. performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Swaarsundar 336 A

State Registrar

3

31. Date filed (Month, Day, Year) JUL 2 9 2004

32. Restrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARNESTOWN ROAD, SUITE: 202, GAITHERS RUAG

MD: 20878.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 9:30A FRANK SHEPPARD 26 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NIA St Agnes Hospital Baltimore If Under 1 Year | II Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, 05 - 14 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months 1**Ø**M 2□F 213-18-7652 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 16 Yes 2 □ No BALTIMORE Directo MO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 AVENUE USA 310 GWYNN Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ARMCO STEEL MACHINE OPERATOR 12 TH GRADE NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANK SHEPPARD, SR MARY HARRISON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WALTER SHEPPARD, JR DR. #4. BALTO. MD. 21229 4113 STO KES Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS 08.02.04 BALTO. MO * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO NATL' PIKE, BALTO MO 21229 21. Signature of Funeral Service Licensee CLA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pheumonia Lynknown Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Prostate Cancer 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

68760, Box o. α. peeu certificate Vital this After Hospitel or Attending Division Director: within 24 hours a

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sician and burial-transit as the use atter for u signed by the a Id be detached f has t page director funeral

Funeral

Director

item 27 is marked other than "neturel", or items 23a or 28e-f show other treumatic event, it is Medical Examples must be notified at

al Hygiene.

is marked of

f Health

to =

permit. Page Department of Importent: if any injury or once.

Physician

Examiner

/Medical

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

4 \ Homicide 29a, Certifier

(Check only one)

cal

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifie MD

Khandagle

D61007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue Baltimore, Maryland 21229

26, 2004 JULY

Kenneth 31. Date liled (Month, Day, Year) State

JUL 2 9 2004

32. Registrar's Signature

Registrar

St. Agnes Healthcare

		-	State of Ma	ryland / Depa	artment of H			giene	23993				
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) Mary Catherine Seth Aa. Facility Name (If not institution, give street and number)		• • • • • • • • • • • • • • • • • • • •	Location of Deat	2. Date of Dea Month July	20 200 4c. County of Do	4 11:00 A ^M				
	Funeral Director		8434 Old Frederick Road 5. Social Security Number 218-14-6029 6. Sex 1 M 2 F 7	o (In yrs. last birthday) Yrs.	Ellicott If Under 1 Year Months Days	_	8. Date of Birth (Month, Day NOV 16,	B. Date of Birth (Month, Day, Year) Nov 16, 1925 Howard 9. Birthplace (State Country) Maryland					
	e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Howard	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No				
	ath with the s 23s or 28 ust be no	Funeral Director	10e. Street and Number 8434 Old Frederick Road	in H.C	10f. Zip Code 21043				Country? States merican Indian,				
9800	72 hours after death with the Maryland natural; or items 23a or 28e-f show dies! Exactive rest by Incilify of	b	11. Marital Status 1 Never Married 2 Marned Forces? 1 Never Married 2 Marned Forces? 1 Yes, Give Year or Dates:	lo	Vas Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🙀 No	Specify:	o Rican, etc.)	Black, W	hite, etc.				
Maryland 21215-0036	within ane. than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	tent's Usual Occup kind of work done DO NOT use retired memaker	ation during most of wo 1)	rking	Own H					
yland	os 1 and 2 should of Health and Mer item 27 Is marke r other treumatic	To Be C	17. Father's Name (First, Middle, Last) John Wesley Lawson			Daisy	/ Irene E						
			19a. Informant's Name/Relationship (Type, Print) Diane Hild - Daughter 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State	8434 20b. Place of Dispo cemetery, cren	Old Fred	derick Ro	pad, Elli	20c. Location - City	or Town, State				
Baltimore,	permit. Page Department of Importent: If eny injury of once.		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Subscription	Maryland	. Name and Addre	ss of Facility Hu	ibbard Fu	neral Hom	le, Maryland e, Inc. ryland 21229				
	Pnysician /Medical Examiner	36	23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) Due to the asset of the cause o					rest,	Approximate Interval Between Onset and Death				
68760,	icate be executed physician and s the burial-transit	dical Examiner	icai	icai	Icai	icai	if any, leading to infiniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cause).	a consequence of):					
.O. Box	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes → Wo 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)	,		23d. Date of o Month	delivery Day Year				
Records, P	v requires the been signed should be de	by	by	by	Part II. Other significant conditions contributing to death be	at not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to 1 ☐ Y 24a. Was a	es 2 3 0 3 0	Probably 4 Unknown autopsy findings available		
Vital Re	Physician: The lav this certificate has ral director, page 2	Be Completed	25. Was case referred to medical examiner?		2.51 POA Oth	or	ath (Check only or	death 2 Np 1 Y	′es 2□No				
Division of	ttending Physical State (1994) the this stor; After this (1994) the funeral displays the funeral displays (1994) t	Certification; To	27. Magner of leath Shatural 5 Pending investigation 2 Accident investigation	y Year) 28b. Time of Injury	28c. Injur Wor	4 🔲 Nursing r	28d. Describe h		pecify) Rural Route Number,				
Ö	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edical Cer	29a. Certifier (Check only one) Check only one) Check only and manner is and manner start.	of my knowledge, death									
)	To the within 2 To the Comple	Med	29b. Signature and title of solition	6b	29c. Licens	e number 5022	9	29d. Date signed (Mo	onth, day, Year) 2 04				
	0		30. Name and existress of person who completed cause of deal of the complete o	eath (Item 23a) (Type, ar's Signature	4660 L	Vicken.	s he.	STE (80	BACT. 2122				
Di	Sta Regist	rar	JUL 2 9 2004	w & A	post								

			1 - For State Registrar		Maryland /	/ Depa		t of H	ealth a		•		2001	23994
	э		1. Decedent's Name (First, Middle, Las	st)		_					2. Date of De			3. Time of Death
	Physici /Medio		Lee Ray Sieber	2							July	24	2004	10:50 PM
17.	Examin		4a. Facility Name (If not institution, give	street and num	ber)		4b. City,	Town, or	Location o	f Death		4c.	County of Deat	n
			Frederick Villa	Nursing	Home				ille				Balti	more
	Funeral Director		496-10-7157 183 Yrs. Aug 28 1920 Mi									nplace (State or Foreign untry) SOURI		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation	<u> </u>						10d. Inside City Limits
	f ehc	ō	Maryland Baltimo	re		1	Baltin	nore						1 ☐ Yes 2 ☐ No
	28a	rec	10e. Street and Number				10f. Zip					10g. Cit	izen of What Co	untry?
	3a or	Funeral Director	5143 Westland Bou	ılevard					21227				Unite	d States
	me 2	era	11. Marital Status		lent Ever in U.S.	13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.))~	14. Race - Ame	rican Indian,
9	or ite	Ξ	1 ☐ Never Married 2 X Married	1 Yes 2		1	1 ☐ Yes		Specify:	, r uento r	wan, etc./		Black, White Specify:	White
93	ours Exi,	1 by	3 Widowed 4 Divorced	Year or Dat	tes:				y.				эреспу.	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow Isa Marical Expeditor nata be mailliad at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	1	6a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation during most	of working	ng	16b. K	ind of Business/l	ndustry
121	han ne	mpl	Elementary/Secondary (0-12)	College (1-	4or 5+)			e retirea)			COL	inty Gov	ernment
	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)			Fore	eman		18. Mothe	r's Name	(First, Middle			CETIMOTIC
anc	ntat h	Be	Jesse Siever								a Atkir		<i></i>	
Ž	should and Men marke	T ₀	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	na Address	(Street a					r Town, State, Z	ip Code)
Maryland	than trau		Jane Sieber / Wif	_	- 1		. (3)							land 21227
ā,	Heelth tem 27 other to		20a. Method of Disposition	.c	20b. Place	e of Dispo	sition (Nan	ne of		D	ate	20c. Lo	ocation - City or	Town, State
JO L	Pages nent of int: if it		1 ☐ Burial 2 【XCremation 3 ☐ `4 ☐ Dogation 5 ☐ Other (Specify		tate I		Cremat			. 7/	29/2004	Balt	imore.	Maryland
Baltimore,	그 든 뿐 글	-	21. Signature Funeral Service Licen	- > -									l Home,	
B	Department of the partment of		Milala	lino '	\sim	4	1107 V	Vilke	ens A	venue	e. Balt	imor	e. Marv	land 21229
	Pnysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on ea	used the death. E ch line.	Do not ent	er the mod	e of dying	g, such as					Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		r as a consequen									
		5	Sequentially list conditions,	b. Due to /c	r as a consequen	ce of):								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events											
	al-tra	Exal	resulting in death) Last	cDue to (c	r as a consequen	ce of):								
760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	cail		d										
89	tificat ig phy as th									-				
Вох	th cer lendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Fetal de		Ectopic pr	egnancy				:	23d. Date of deli	
	be att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna 9□Unknov	nt at time of death	n 5□	Other (sp	ecify)					Month	Day Year
P.O.	at the	Phy	9 Unknown			e in the co			n in Cont I		22a Did t	obacco u	ica contributa to	the cause of death?
	Se Lib	b	Part II. Other significant conditions of	diffibuling to dea	atii bat not iasaitin	ig iii tii e ui	ndenying c	ause give	miirani.		1 🗆			babiy 4 Munknown
Records,	w require been si should I	Completed									<u> </u>			
Sec.	e law has b	npl									24a. Was auto		prior to c death?	topsy findings available ompletion of cause of
al F											1 Yes	2 No	1 ☐ Yes	2 12 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	300		(Check only o		- 50	
of	ding Phyelclan: After this certific funeral director,	To	1 Yes 2 100	1 ∐ In 28a. Date of	patient 2 ER/	Outpatier b. Time of		A	4 (2) 1401		ne 5∟Resi 8d. Describe		6 □Other (Spec	ify)
on	ding h. Afte	tion	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month	, Day Year)	Injury	М	8c. Injury Work 1 🔲 ۱	(? Yes 2□N	No			1	
Division	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	e 28e. Place o	of Injury - At home	, farm, str	eet, factory	, office		2	8f. Location (Street an	d Number or Ru	ral Route Number,
D.	afor after I Dire	Certification;	4 Homicide	buildin	g, etc. (Specify)						City or To	wn, State)	
	To the Hoepital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical C	29a. Certifier 1 Lecrtifying Ph (Check only 2 Medical Examone)	ysician: To the t niner: On the bas and manne	sis of examination	dge, death and/or in	h occurred vestigation,	at the tim in my op	e, date and pinion, deat	d place, a h occurre	nd due to the d at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier	1.1.					number				e signed (Month	
	\		> plural-4	- xun				445	127			July	27, 2	004
(7x 1		30. Name and address of person who person who person Pigra	completed cause	of death (Item 23	a) (Type,	Print) +L761	its n	NENC	E E	BALTIM	10RE	= MD	21208
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature	9								
	Regist	rar	JUL 2 9 20	104	we It	E.	colle)							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer **Physician** Edward N. Shores a N 2004 July 24 6:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Annapolitan If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 ₹M 2 □ F Months 80 212-20-4834 Director Nov 8 1923 Maryland Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Medical Examinat must be multified at 1 ☐ Yes 2X No Glen Burnie Maryland Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 United States 1903 Pagham Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates: Specify: 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed **CPA** 12 4 18. Mother's Name (First, Middle, Maiden Surname)
Mary M. Wright 17. Father's Name (First, Middle, Last) nd Mental i Frank N. Shores 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8073 Foxwell Road, Glen Burnie, Maryland 21061 Richard E. Shores / Son f Health Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 = 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 7/28/2004 Baltimore, Maryland 4 ☐ Denstion 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** revenionia weed disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** aclerema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner many years The law requires that the death certificate be executed buriat-transit NIDDA Due to (or as a consequence of) Box 68760, physician Physician/Medical ije. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other. 4 Nursing Home 5 Residence ther (Specify) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 SeNo his Living 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) determined 4 Homicide 24 hours a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the the within 3 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 7/26/04 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUSAIRED, Mp. 1401 Madison Park, Glen Busnie, 21061 32. Registrar's Signature 31. Date filed (Month, Day, Year) State place of foods

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 00 Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** -: 3.5 9 M **2**1 Smith 2004 Sonya /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore

| House 1 Year | House 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 1 10 71 Stella Maris Hospice 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F intry) MD Yrs. 32 Director 2-99-5638 Usual Residence of Deceder 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinas must be notified at MYes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21215 4619 Reisterstown Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Des 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Restaurant Waitress 10th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ronald Ragins Gwendolyn Smith-Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4614 Gravel Rock Ct., Las Vegas, NV 89081 Antuan Smith-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 7/28/04 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) King 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 21215 Baltimore, 4300 Wabash Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of Pnysician uncer disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): Box 68760, the attending physicien Physiclan/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 □ Yes 2 □ No 4☐Pregnant at time of death 5 Other (specify) detached P.O. 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown been signated b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No 1 Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 2 No ٥ 1 Tyes 3 DOA er (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D40854 7/21/2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Paul Pl Bultmar Risebergi MD 301 21202 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AMPSON **Physician** DORO 8.23 AM 07 28 /Medical 4b. City, Jown, or Location of Death 4c. County of Death 4a. Facility Name (If not institution give street and number) Examiner Drvin If Under 1 Year Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (S Country) 0 7 //8 //926 Mary Land Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** 1□ M 2 F Days Months Hours 212-20-509 Yrs 78 Director Usual Residence of Decede parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena. Important: If Item 27 is marked other than "netural" any injury or other traumatic average. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No NA Baltimore MD Funeral Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street end Number USA 21201 1102 Druid Hill Avenue #1112 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 No if Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 Ø Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homes Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Annie Johnson Charles Simms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald Sampson/Son 1102 Druid Hill Avenue #1402 Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8/3/04 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Mt.Zion Cemetery Funeral Serice Licenses 22. Name and Address of Facility Wylie Funeral Home 638 N.Gilmor St. Balto,MD21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Piysician thero Scleratic Cardinascular Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner attanding physician and for usa as tha bunal-transit Hospital or Attending Physician: The law raquiras that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physiclan/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i is cartificata has been signed by the a director, paga 2 should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed' 20No 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Certification: To Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this 28d. Describe how injury occurred the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 27. Manner of Death 112 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No aftar death Director: / 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

within 24 hou To the Fune completaly fi To the

> State Registrar

-1AQ 31. Date filed (Month, Day, Year, JUL 2 9 2004

29b. Signature and title of certifie

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

luce

32. Registrar's Signature

DHMH 16 Rev 6/95

	1 _ State	d / Department of Health and M Certificate of Death	2.0.		
	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death	3. Time of Beath	
Physician /Medical	FLOYD JAMES SMITH		JULY 24 2004	9:08 PM	
Examiner	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPIT	4b. City, Town, or Location of Death FREDERICK	4c. County of Deat		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Feb 18, 1945 M.	thplace (State or Foreign ountry) aryland	
 ₽	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Location		10d. Inside City Limits	
Maryla Maryla Fled at	M1 F1-	Middletown		1 ☐ Yes 2 🛣 No	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel" or Items 23s or 28s-1 show any Injury or other treumstic event, the Medical Examinating the profitted and once. To Be Completed by Funeral Director	10e. Street and Number 6731-A Burkittsville Road	10f. Zip Code 21769	10g. Citizen of What Co	puntry?	
of the death value of the control of	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-		
036 urs after articles	1)X Never Married 2 Married 1 Sec. 2XXVo If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		hite	
5-00	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working)	16b. Kind of Business/	(Industry	
Maryland 21215-0036 to 2 should be filed within 72 hours aff the and Mantal Hyglene. 27 is marked other than "naturel", or treumatic event, the Medical Exert. To Be Completed by F	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of workir life. DO NOT use retired) Painter		Contractor	
ind 2 be filed tal Hygi d other event, I	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame)		
ylar ould b Menta varked varked	noward James	Smith Beulah	Marie	Corum	
Mar d 2 sh th and th and treum treum	19a. Informant's Name/Relationship (Type, Print) Esther D. May/Sister	19b. Mailing Address (Street and Number or Rural 119 West 5th Street, F	•		
re, s 1 an f Heal item 2	20a. Method of Disposition 20b. F		ate 20c. Location - City or		
Page:		sthaven Mem Gardens Jul 2	28, 2004 Frederich	k, Maryland	
Baltimore, permit. Pages 1 at Department of Hea Important: if item any Injury or othe once.	21. Signature of Euneral Service Licensee MOC	22. Name and Address of Facility Keeney & Basford 1706 106 East Church St	P.A. Funeral Home	and 21701	
	23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.		respiratory arrest,	Approximate Interval Between	
Physician	Immediate Cause (Final disease or condition resulting in death)	Lung Carcinoma - Mctastati	Ĺ	Onset and Death Unknown	
/Medical Examiner	Due to (or as a conseq	pence of:		Soyears	
Je Je Je Je Je Je Je Je Je Je Je Je Je J	Sequentially list conditions.	100000		J 1000	
o, executed in and ial-transit Examiner	Cause (Disease or injury that initiated events c	uence of):			
a cig be	d d	33.63 3.7.			
ox 687 certificate Inding physicals as the Investment I	IE ECMALC.				
Beath death death dror of for of the second dror of the second dror of the second dror of the second dror of the second dror of the second dror of the second dror of the second dror of the second dror of the second drop drop drop drop drop drop drop dro	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnat 4 □ Pregnant at time of d 9 □ Unknown	I death 3 ☐ Ectopic pregnancy	23d. Date of deli Month	ivery Day Year	
P.O. that the detache detache		ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?	
ords, requires the hould be contained by the signs of the hould be contained by the signs of the sign of the sign	1. Alcohol Abuse		1√Yes 2 No 3 Pr	obably 4 Unknown	
Vital Record Vital Record steien: The law requir certificate has been si rector, page 2 should	2. Diabetes Mellitus		24a. Was an autopsy findings prior to completion of c death?		
Vital R Vital R stcien: The	25. Was case referred to medical	26. Place of Death		2 □ No	
of Vita of Vita Physicien: this certific	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	Other	ne 5 Residence 6 Other (Spec	cify)	
On o		28b. Time of Injury M	8d. Describe how injury occurred		
Division of tell or Attending P is after death. el Director: After tell in by the tuners Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At he		8f. Location (Street and Number or Ru	ıral Route Number,	
DIV s after el Dire ed in b	4 Homicide determined building, etc. (Specific	0	City or Town, State)		
Division of Vital R To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page		wledge, death occurred at the time, date and place, a tion and/or investigation, in my opinion, death occurre	nd due to the cause(s) and manner as id at the time, date and place, and due	stated. to the cause(s)	
To the within To the comple	29b. Signature and title of cartifier	29c. License number	29d. Date signed (Month		
	> Silman M.D.	000 55793	7-25	-04	
10	30. Name and address of person who completed cause of death (Item	redcrick Memorial Hispital			
State Registrar	31. Date filed (Month, Day, Year) JUL 2 9 2004 32. Registrar's Signa	b spark			

Registrar DHMH 17 Rev 1/2001

ORIGINAL

Spale

State of Maryland	Department of Health	and Mental Hygiene

			For State Registrar	State of Mar	•	artment of		nd Me	, ,	antes anti-	301	
			Decedent's Name (First, Middle, Last)					2. Date of Death				
	Physici		ANTHONY L.	SCHUELE	R			-	Month	Day 25	2004	5:30 pM
To all	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town,	, or Location of				nty of Death	Р
	LXamii	eı	BAYVIEW GERIATR		R	BAL	TIMORE	F.			N/A	
	Funeral		Social Security Number 6. Sex		In yrs. last birthday)	If Under 1 Yea	ar If Under 24	4 Hrs. 8	Date of Birth		0 Right	lace (State or Foreign try)
	Director		214-38-1228 ¹⁸⁰	M 2 F	65 Yrs.	Months Day	s Hours	Min.	(Month, Day, AUG. 5	,193	8 MA	RYLAND
	pu ,		Usual Residence of Decedent 10a, State 10b, County	1.	On City Town and						1.	
	aryla shov	_		'	Oc. City, Town or Lo						10	0d. Inside City Limits 1 XYes 2 □ No
	Ba-f	Director	MD. N/A		BALTIN					- 011		
	death with the Maryland ims 23s or 28s-f show I Intel Le multing at		10e. Street and Number	0mp ====		10f. Zip Code			110	-	of What Coun	try?
	s 23	era	819 S. OLDHAM	STREET 2. Was Decedent Eve	or in II C 12	21 Was Decedent of	224	in 2 /Conneil	h. Van as Na		S.A.	an Indian
	ter de Item	Funeral	11. Marital Status 1 Never Married 2000 Married	Armed Forces? 1 ☐ Yes 2 [X]No	61 III Q.G.	If Yes, specify Cu	uban, Mexican,	Puerto Rio	an, etc.)		lack, White,	
8	hours after turs!; or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21X N	o Specify:			Spec	cify: WHI	TE
21215-0036	72 hou	ted	15. Decedent's Educ	ation		dent's Usual Occ			1	6b. Kind of	Business/Ind	
21	within 7 ene. than "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work don DO NOT use retii	red)	or working				
21	giene giene er tha	Completed	N/A	,		DISABLE	D			N	/A	
nd	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural; or items 23s or 28s-f show svent, I're Medical Exerting I mail be rediffed al	Be (17. Father's Name (First, Middle, Last)				18. Mother's	's Name (F	First, Middle, M	laiden Sum	am <i>e)</i>	
Va		2	ELMER ERWARD	SCHUELE			MAR		ROTUND			
Maryland	2 should be and Mental is marked is marked is marked is marked is marked in the same in th		19a. Informant's Name/Relationship (Typ			ng Address (Street						
	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		MARY MARLL/ MOT	HER	819 20b. Place of Dispo	S. OLD	HAM ST	REET				
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re		cemetery, cre	matory or other p	1				n - City or To	
ţim	t. Pa rtmen rtent: njury		' 4 ☐ Donation 5 ☐ Other (Specify)		HOLY RED			-	_		IMORE	
Bal	permit. Page Department of Important: If sny injury or once.		21. Signature of Funeral Service License			ILLY &	ZEILE	ER IN	IC. FU	NERAI	L HOM	E
			23a. Part1. Enter the disease, or complic	eations that caused th	e death. Do not en	00 S.	CONKLI	NG S	STREET	BALT	ro., MI	D. 21224 Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	,		-	_	oophatory arre	J.,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Coron	ary Av	tery]	Disea	ISE				years
	Examiner			Due to (or as a o	onsequence on:)						
*		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a o	опъециенов от.						- 11	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
o,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a o	consequence of):							
8760	the death certificate be executed y the attending physicien and Iched for use as the burial-transi	dical	d									
9	rtifica ng ph as ti	0 0	IF FEMALE:							-1		
Вох	eath certific attending p	an/M	23b. Was decedent pregnant in the past 12 months?	sc. If yes, outcome of 1□Live birth 2 [Ectopic pregnan	псу				Date of deliver	ry Day Year
	the at	sici	1 Yes 2 No	4☐Pregnant at tin 9☐ Unknown	ne of death 5	Other (specify)					elorite)	Day Toal
P.0	that the de led by the detached	Physicia	Part II. Other significant conditions con	ributing to death but	not resulting in the u	nderhing cause o	aven in Part I		23e Did toh:	acco use co	ontribute to the	e cause of death?
Vital Records,	Se Go	l by	Cerebrovasculo		A		g: • O: 1		1 ☐ Yes			
O	w requir been si should	Completed						_	04-146	, <u>,</u>		
36	has has	m	Diabetes mel						24a. Was an autopsy perform	' 1	prior to con death?	osy findings available apletion of cause of
<u>a</u>		e Co		cenal bi	sease				perform 1 ☐ Yes 2		1 🗆 Yes	2□ No
	S C G	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	ospital: 1 Inpatient	2 ER/Outpatie	3000			Check only one 5 ☐ Resider		Mhas (Casaife	1
of		F 1	27. Manner of Death	28a. Date of Injury (Month, Day Y		f 28c. Inj	ury at		d. Describe how)
on	ith. :: After e funer	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ear) Injury		lork? □Yes 2□No	0				
Division	el or Attending s after death. sl Director: Afte	if Ca	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, st	eet, factory, office	е	28f	Location (Stre City or Town,		nber or Rural	Route Number,
ā	s afte	Certification:	4 El Homicido	bulldarig, etc. (Specify)				ony or rown,	State)		
	To the Hospitel or Atterview within 24 hours after de To the Funeral Directo completely filled in by the	edical	29a. Certifier (Check only 2 Medical Examin	ician: To the best of r	ny knowledge, deat	h occurred at the	time, date and	place, and	d due to the car	use(s) and r	manner as sta	ated.
	To the H within 24 To the F complete	ledi	oney	and manner state	d.			. 000011100				
	No To	Σ	29b. Signature and little of certifier	(mo		nse number				ned (Month, E	
	1		(Januar V	-/	·	Delan)	OTUS		J	uly .	26Th,	2004
	17			npleted cause of deal		Bayri	en Ci	rde,	, Balti	more	MD	21224
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature							•
	Registr	rar	RH 9 0 2	101	11	Acart .						

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Da Month Year **Physician** Speller, Jr. Joseph 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT A HEALTHCARE SALTIMORE HANES NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 2-14-6. Sex 1⁽¹ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months. 219-38-5632 59 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ehow r itams 23a or 28a-f ehov intermust be notified at 1 XYes 2 □ No Director NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2122 E. Hoffman St. 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ö 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Specify: Black Š the Medical Exac 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Yellow Freight 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental Joseph Speller , Sr. Mamie Eldridge 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Alvin Eldridge Brother 1718 Wolfe Street, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō rtant: If i 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State perrit. Page Department of Important: If any injury or once. 8-2-04 Mt. Carmel Cem. Dundalk, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 /lela March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Toute in 40 Cardio toute intarction disease or condition resulting in death) /Medical **Examiner** ARDIOMYOBATITY Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of Examine The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably ♦ Unknown DIABETES MELLITUS Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CONGESTIVE HUART PAILURE has l autopsy performed? certificate VENTRICULAR TACHYCARDIA 1 Yes 2/1 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 💋 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Diractor: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 🕱 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DZZGYF nd address of person who colleged cause of death (Item 23a) (Type, Print) lucy 27, 2004 P LECOME I SNYDER MO 900 SOUTH CATEN AVENUE BALTIMORE MARYLAND 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 9 2004 Registrar park